MENTAL HEALTH BILL 2013

Consideration in Detail

Resumed from an earlier stage of the sitting.

Clause 224: Report to Chief Psychiatrist and Mentally Impaired Accused Review Board —

Debate was interrupted after the amendment moved by Dr A.D. Buti had been partly considered.

Clause put and passed.

Clauses 225 to 227 put and passed.

Clause 228: Principles relating to use of bodily restraint —

Dr A.D. BUTI: Sorry, I was a bit distracted; I am trying to work out where I am.

Ms R. Saffioti: You're in Parliament.

Dr A.D. BUTI: Yes, I am in Parliament; thank you very much. I move —

> Page 166, after line 16 — To insert —
>
> (c) bodily restraint should be regarded as a treatment of last resort.

I moved this amendment because there are a number of clauses throughout the bill that provide for infringement on the patient. Of course, because we are dealing with mental illness, there will be some cases in which the person will need to be restrained for their own good or for the safety of the community. But we must always be on guard to ensure that we minimise the ability of the state to restrict the freedoms of its citizens. That virtue is held important to the heart of the Liberal Party, or so it says.

Mr P. Papalia interjected.

Dr A.D. BUTI: That is right. The Liberal Party always talks about small government, but when it comes to interfering in people's freedom of movement and moral issues, the Liberal Party of Western Australia has never been reticent to enact legislation.

The objects of the bill, which are dealt with in clause 10, refer to minimising the restraints that are imposed on a person who is the subject of the bill. The purpose of my amendment is quite clear. If a bodily restraint is to be used—of course, a bodily restraint amounts to significant interference with a person's freedom—it should be a treatment of last resort. The parliamentary secretary might tell me that that would be the case anyway, but we are trying to comply with the objects of the legislation. Any clause that may result in restricting a person's freedom should include an express provision that curtails the interference with those freedoms. My amendment to clause 228 seeks to ensure that bodily restraints will be regarded as a treatment of last resort. It is a logical amendment to clause 228 and it complies 100 per cent with the objects of the bill, which is why the opposition has moved it.

Ms A.R. MITCHELL: Unfortunately, the government does not agree with the amendment.

Dr A.D. Buti: Why is that?

The SPEAKER: Just wait a minute, member for Armadale.

Ms A.R. MITCHELL: A bodily restraint is not a form of treatment; rather, it is an intervention. The member used the word "treatment" in his amendment, but a restraint is not a treatment.

Dr A.D. Buti: Is that the only reason?

Ms A.R. MITCHELL: No, I have not finished speaking.

Clauses 228(b)(i) and 232 indicate that a bodily restraint is to be used only when all less restrictive forms have been considered and deemed to be inappropriate at that stage. Clause 228(b)(i) reads —

> there must be the least possible restriction on the person's freedom of movement consistent with the person's restraint …

Clause 232(1)(b) reads —

> there is no less restrictive way of providing the treatment or preventing the injury or damage …

Those are the government's reasons.

Mr P. PAPALIA: I understand that the parliamentary secretary has been told that she does not have the authority to think about and act on any amendments—that is fine. What the parliamentary secretary just said does not support her argument. The subclause does not read, "this is the option of last resort". It states that there

must be the least possible restrictions on a person's freedom of movement consistent with a person's constraint and that the person must be treated with dignity and respect. It does not state that that is the last thing that is done. It does not state that restraining someone is the last possible option, which is the sense of the amendment moved by the member for Armadale. If the parliamentary secretary does not like the word "treatment" in the amendment, she should change it. I am sure that the opposition would accept that.

Mr P. ABETZ: My understanding is that if a person is taken to a mental health facility, for example, and requires an injection but is in a very disturbed state, the first course of action is physical restraint. A restraint cannot be regarded as the treatment of last resort, because a person may have to be restrained to initiate treatment. The amendment does not make a lot of sense.

Mr P. PAPALIA: It is a decision-making process. The amendment is designed to guide the people who will impose options, with a restraint being one of them.

Dr K.D. Hames: They don't need guidance.

Mr P. PAPALIA: That is interesting. If they do not need guidance, we do not need the legislation because every single time they will act absolutely in the manner that Parliament expects from them because they have extrasensory perception! The reason for having the legislation is so that we can dictate what can and cannot be done in this very specific and sensitive field in which people are vulnerable. It is not good enough to say that they know what to do and therefore we do not have to give them guidance, but that is what legislation is designed for. Just because the bill states that this particular form of treatment—or, as the parliamentary secretary would prefer, a word other than "treatment"—is the option of last resort, that means that a person has gone through the thought process, however quickly, to determine other options and has deemed that one to be appropriate because it is the only one that will work. That means it is the option of last resort. It is the same for any other list of options. Just saying that it is the last resort does not mean that it will not be used first; rather, it means that a person will have quickly gone through and assessed all the options and decided that this is the appropriate one. The person has checked all the other options and decided that none of them will work, so that is the one that has to be used.

Ms A.R. MITCHELL: The aim is to minimise the use of restraints. The government does not encourage their use straightaway. However, there will be situations in which it is necessary; therefore, it should be available, but not as a last resort. Clause 232 focuses on the criteria for authorising bodily restraints.

Dr A.D. BUTI: I refer to what the member for Riverton said. Not every mentally ill patient will be violent or present in a violent matter. Of course, if a person needs to be restrained, he should be restrained. The opposition is saying that he should not be restrained if he does not need to be restrained. A restraint should be a measure of last resort. Of course, if a person is violent, his body should be restrained. The member for Riverton's assumption is that every person with a mental illness is a violent person who needs to be restrained. If that is not the case, it should be an expression of the state's intention that bodily restraints be a measure of last resort. The member can refer to the criteria by which one has to go before authorising bodily restraints, but those criteria do not equate to being a measure of last resort. Where in clause 232 does it state that it is a measure of last resort? I cannot find it.

Mr P. ABETZ: I think the member for Armadale will find that *Hansard* records that I said "if" a person comes in in an agitated state and needs to have an injection—it is "if". If we pass an amendment that states that bodily restraints should be regarded as a treatment of last resort—as the parliamentary secretary said, it is not a treatment—physical restraints will enable treatment to take place. Clause 228(a) clearly states —

> the degree of force used to restrain the person must be the minimum that is required in the circumstances …

That makes very clear the requirements of any medical practitioner or nurse in a mental health institution. If a person needs to be restrained to be given an injection, he does not need to be tied hand and foot; he simply needs to be restrained for a minute or two to allow the injection to be given. Clause 228(a) covers the intent of the member's amendment.

Ms A.R. MITCHELL: I do not like discussing clause 232, because we have not reached it.

Dr A.D. Buti: You brought it up.

Ms A.R. MITCHELL: I did not wish to raise it in response.

The term "last resort" does not help in this situation. Clause 232(b) states that a person cannot make a bodily restraint order unless that person is satisfied that —

> there is no less restrictive way of providing the treatment or preventing the injury or damage …

Clause 228(b)(i) reads that while a person is restrained —

there must be the least possible restriction on the person's freedom of movement consistent with the person's restraint …

We believe we have covered what the member has said, without saying it is the last resort.

Amendment put and negatived.

Clause put and passed.

Clauses 229 to 239 put and passed.

Clause 240: Report to Chief Psychiatrist and Mentally Impaired Accused Review Board —

Dr A.D. BUTI: I move —

Page 176, after line 31 — To insert —

(ba) the Chief Mental Health Advocate; and

This is consistent with a number of clauses in this bill that I have sought to amend to give legislative expression to an increased status for the Chief Mental Health Advocate. Time and again when I have moved amendments during this consideration in detail stage with regard to the Chief Mental Health Advocate being acknowledged or being informed about certain things that may happen, what I get from the parliamentary secretary is that it is an administrative burden. It is actually not an administrative burden. It is ridiculous to say that it is an administrative burden to require that documents that are provided to the Chief Psychiatrist and the Mentally Impaired Accused Review Board be provided also to the Chief Mental Health Advocate. We are either going to be serious about the role of the Chief Mental Health Advocate or we are not. The parliamentary secretary should not say that the Chief Mental Health Advocate has the right to represent someone but then not give that person the legislative status that they should be given. The Chief Mental Health Advocate is either a serious player in the mental health scenario and in the legislative regime or they are not. At the moment, the Chief Mental Health Advocate is not a serious player, because the government is not willing to give the Chief Mental Health Advocate the status that they should be given. What are we dealing with here, members? We are dealing with some of the most vulnerable people in our society, who may be bodily restrained, may be detained for many hours, may be subject to treatment that they have not consented to, and may be made an involuntary patient. One of the ways in which we can ensure that the rights of these people are preserved is by having the Chief Mental Health Advocate. But time and again, this government has refused to give the Chief Mental Health Advocate the status that they should be awarded. It is ridiculous for the parliamentary secretary to say that the Chief Mental Health Advocate can find out that information in any event. Yes, they can find it out, but they will have to search for it. Why does the Chief Psychiatrist or the Mentally Impaired Review Board not have to search for that information? The parliamentary secretary knows that it will reduce their workload if they are informed of certain procedures or certain treatments that have commenced or have come to an end. Time and again, the parliamentary secretary has refused to give the Chief Mental Health Advocate the credit that person deserves under this legislation.

Mentally ill patients need to be given the protection of an advocate. That is why the government has created the position of Chief Mental Health Advocate. However, that person cannot operate properly if the government is not prepared to give that person the assistance that is provided under this bill to other parties that may be imposing restrictions on the patient. The role of the Chief Mental Health Advocate is to ensure that only the appropriate restraint and interference with freedoms takes place. If other people in the regime know that the Chief Mental Health Advocate will be receiving certain information, I would hope that would increase their diligence and compliance. Part of the rationale behind CCTV is that if people know they are being watched, they will behave in a proper manner. If people know that the Chief Mental Health Advocate will be given certain information automatically and will not have to ask for it—information that they may not even know about—hopefully that will improve the compliance of other people under the bill and improve the care of mentally ill people.

Ms A.R. MITCHELL: I thank the member. I reassure the member—I do not think I should have to do this—that we place a great deal of importance on the Chief Mental Health Advocate. We have introduced such a person into this bill. There is a clause in the bill that deals with the Chief Mental Health Advocate. That is how important we believe this position is. However, we see the roles of the Chief Psychiatrist and the Chief Mental Health Advocate as being very different; one is clinical, and one is advocacy. Therefore, I do not think we should compromise by duplicating the work that each of those persons will be doing. Clause 358(1)(f) makes specific reference to the information that not just the Chief Mental Health Advocate but mental health advocates will have access to on behalf of these people. In no way are we trying to downplay the role of the Chief Mental Health Advocate. We have introduced the concept. We are very pleased to have that position and that of mental health advocates. But we do not believe that the role of the Chief Psychiatrist and the Chief Mental Health Advocate are to be considered the same throughout this bill.

Dr A.D. BUTI: Of course they have different roles. But that does not mean that they should not receive similar information. The parliamentary secretary said that she has introduced the role of Chief Mental Health Advocate. If she has introduced the role, that person should be given the legislative tools to enable them to perform their role appropriately. The member for Fremantle interjected to say that that person should also be given the legislative recognition that has been given to other parties. Yes, the role of one is treatment, and the role of the other is advocacy. But surely advocacy is just as important as treatment if we are to comply with the objects of the bill. It is important to go back to the objects of the bill. I will read this out, because it does not seem to be getting through to the parliamentary secretary. The bill states in clause 10, "Objects"—

> (1) 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; …

The Chief Mental Health Advocate cannot achieve those objects if that person is not given the appropriate tools to perform their role; and that person will not have the appropriate tools to perform their role if they are not provided with the information that they need to be provided with. There is no budgetary issue here in providing information to the Chief Mental Health Advocate. I will tell members what the story is here, and I hope that when we get back into government, we have learnt from this exercise. I hope that we will not oppose opposition amendments just because we do not want any opposition amendments to get up. The parliamentary secretary has provided no rational explanation for why the Chief Mental Health Advocate cannot be provided with the information that that person would be provided with under the amendment that I have moved.

Ms A.R. MITCHELL: We believe that this bill expands the role of advocates for the people who require their services. The role of the Council of Official Visitors has been expanded into the Chief Mental Health Advocate system and the available mental health advocates. More groups of patients have access to mental health advocates. There is listed automatic contact with involuntary patients. Therefore, we have increased the opportunity for patients to access advocacy services, and we believe that there is no need for the member's amendment.

Division

Amendment put and a division taken, the Acting Speaker (Mr N.W. Morton) casting his vote with the noes, with the following result —

Ayes (14)

Ms L.L. Baker	Mr F.M. Logan	Mr P. Papalia	Mr P.C. Tinley
Dr A.D. Buti	Mr M. McGowan	Mr J.R. Quigley	Mr D.A. Templeman *(Teller)*
Mr R.H. Cook	Ms S.F. McGurk	Mrs M.H. Roberts	
Mr D.J. Kelly	Mr M.P. Murray	Mr C.J. Tallentire	

Noes (31)

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

Pairs

Ms J. Farrer	Ms W.M. Duncan
Mr W.J. Johnston	Mr T.R. Buswell
Ms R. Saffioti	Mr D.T. Redman
Ms J.M. Freeman	Dr G.G. Jacobs
Mr P.B. Watson	Mr J.E. McGrath

Amendment thus negatived.

Clause put and passed.

Clause 241: Physical examination on arrival at hospital —

Dr A.D. BUTI: I move —

> Page 178, line 20 — To insert after "condition"—
>
> > and the medical practitioner must contact all medical practitioners who are currently treating the admitted person to discuss the physical and mental health needs of the patient

Clause 241 covers the health care of people in hospital. It is in division 1, "Examination to assess person's physical condition". Patients are to have a physical examination on their arrival at hospital, and they are to be examined when they are discharged, as stated in clause 241(2), which states —

> … must ensure that as soon as practicable and, in any event, within 12 hours after the time when the person is admitted or received, a medical practitioner physically attends on the person for the purpose of examining the person to assess the person's physical condition.

The opposition argues that other medical practitioners who are currently treating the person for their physical or mental health needs—we are not looking at history of three or four years ago—should also be included in this process. This is important because the medical practitioners currently treating the patient will have greater in-depth knowledge of the patient.

Ms A.R. MITCHELL: I am advised that the word "examining" in this context, in medical terminology, includes everything that the member has just said. The recommendation in this amendment is unnecessary because the examination requires the history of treatment and contact with the patient's practitioners for the medical history, whether recent or past. The examination involves all those things; it is a comprehensive approach to the examination of the patient, not a simplistic examination of the patient.

Ms S.F. McGURK: I am surprised that the parliamentary secretary said that, because it is logical to me that the current reading of clause 241(2) of the bill refers to a comprehensive physical examination of the patient. The member for Armadale's proposed amendment requires that the practitioners carrying out that examination contact and consult other treating practitioners to give their opinions on the state of the patient. I am sure there have been many examples of mental health patients not informing their current treating practitioner or other practitioners who have treated or are treating them, or the patients may be unaware of the opinions of the other practitioners treating them. This proposed amendment is entirely sensible and would only enhance the knowledge available to the practitioner making a treatment decision under clause 241(2). I imagine that would enhance the practitioner's decision-making process.

Ms A.R. MITCHELL: Perhaps I was not clear enough when I said that the practice of examination includes contact with other practitioners and being informed of history of treatment and contacts. We agree; all those people who may be involved, in a clinician sense, support and highlight the principle of collaboration, but it does not mean that every bit of good practice needs to be spelt out throughout this bill. That practice is supported and we agree with it but it does not need to be set out again because that is how clinicians operate.

Ms S.F. McGURK: I take issue with that. I am not a medical practitioner, obviously, but I do not think anything in clause 241(2) requires the practitioner making that assessment to contact other treating practitioners of the patient. I am glad to hear that the parliamentary secretary agrees with the member for Armadale's rationale behind the amendment. If she does agree, good legislation would be clear on this point. I can only imagine that it has been the bane of many families and people involved with assisting in the care of mental health patients because they are frustrated that other treating doctors are not consulted when decisions are made.

Ms A.R. MITCHELL: We have accommodated that also in the clinicians guide that will be produced for people to make sure it is clear, but we will certainly not include every bit of good medical practice in the legislation because, as we all agree, this bill is fairly large. That will be reinforced within the clinicians guide, as is good medical practice now.

Ms S.F. McGURK: As I said, it seems to me that it is not a cumbersome or superfluous amendment. It makes clear what would be good practice, which, as I understand it often does not happen. For instance, in a busy hospital where resources are stretched and decisions are being made about a mental health patient, perhaps some effort is made to contact that patient's other treating practitioners, but that is often not the case. I know that to be the case in some instances. I imagine, as I said, that families and carers, let alone patients in times of lucidity, might be frustrated that the practitioner at the time did not make more effort to contact other health professionals treating the patient. It is not always the case, parliamentary secretary. I absolutely take issue with her comments. It would make for good, clear legislation if the parliamentary secretary agreed to this amendment.

I am wondering whether during the course of this debate the parliamentary secretary has thought good suggestions from this side of the house have been made at any time. I am not sure that has been the case, but in this case, the two and a bit lines that make up this amendment will only serve to provide good care of mental health patients covered by this bill.

Ms A.R. MITCHELL: The inclusion of this clause on examination is new to this bill. There is no requirement for examination in the current act. That is why the member is right, but the examination requirement is in this bill, so it will be different.

Dr A.D. BUTI: It is all right for the parliamentary secretary to say that this provision refers to an extensive comprehensive examination but the bill does not say that. If that is the case why do we have legislation? As the parliamentary secretary stated in, I think, her second reading speech, this is a very prescriptive bill because certain things need to be done when dealing in the mental health area. We have moved this amendment to mandate what should happen. As the member for Fremantle stated, it has not happened in the past. One of the parliamentary secretary's responses was that it is not in the act and now the government has included this provision so that it will happen. There are a lot of gaps in that logic because nothing in that subparagraph will mandate what this amendment seeks to do. My question to the parliamentary secretary is: if a person does not consult current treating medical practitioners, what will be the sanction? There can be no sanction because it is not mandated under the legislation that they do what we are seeking with this amendment. The parliamentary secretary cannot mix law and policy. She is saying that this will happen because it is policy. But the legislative framework that is supposed to enact the policy does not equate under this clause. What I am seeking under this amendment is not mandated. The parliamentary secretary can go on and on about what will happen but that is not necessary under the wording of clause 241(2).

Amendment put and negatived.

Clause put and passed.

Clauses 242 to 246 put and passed.

New clause 246A: —

Dr A.D. BUTI: I move —

Page 182, after line 31 — To insert —

> **246A. Psychiatrist to notify State Administrative Tribunal**
>
> A psychiatrist who makes an involuntary treatment order must notify the State Administrative Tribunal to appoint a guardian for the limited purpose of arranging legal representation for the patient as necessary.

Under clause 25 we discussed the criteria to determine who could be an involuntary patient. The opposition took issue with what we thought was a very broad, catch-all clause that could even include damage to reputation. We find it amazing that damaging one's own reputation could lead to someone being made an involuntary patient. I can tell the parliamentary secretary that if someone were made an involuntary patient that would damage their reputation, regardless of how they behaved; it would be more damaging to their reputation than most things. If someone who is not a mentally ill patient is behaving in a manner in which they are considered to be damaging their reputation, so be it. If a mentally ill patient is doing something that might be a bit embarrassing or damaging to their reputation, they can be admitted to hospital as an involuntary patient. There is a much more stringent test around damage to reputation for people who have a mental illness than for people who are not mentally ill. We lost that argument when we debated clause 25, so I have moved to insert this new clause. We are saying that once a psychiatrist makes an involuntary treatment order—remember it is an involuntary treatment order—that will, of course, reduce the patient's control over their life, so a guardian needs to be appointed for the limited purpose of arranging legal representation for the patient.

As we know, although there is not an absolute legal right to representation in the criminal justice system, as explained by the High Court case of Dietrich, there near enough is, especially for serious offences. That is dealing with someone who has allegedly committed a criminal offence and is of sound mind and can make decisions. Presumably, in the case of an involuntary treatment order, the person's ability to represent themselves and look after their own interests is severely diminished or does not even exist, otherwise why is an involuntary treatment order in place? In that case, they must have the ability to have legal representation. If a psychiatrist has made an involuntary treatment order, presumably that patient does not have the capacity to arrange their own legal representation. More than likely they will not, otherwise why would an involuntary treatment order be made? In that situation it should be paramount for the state to ensure that opportunities for legal representation are made available to that patient. The state must provide that, but in this situation the state is intruding on the patient and an involuntary treatment order has been made. This has not been done with the consent of the patient or with the patient having the ability to make decisions, and this is not being done with the patient having made an informed choice; it has been made in the situation of the patient not having capacity. That is why there must be provisions for legal representation, and that is why we have moved the amendment.

[Quorum formed.]

Ms A.R. MITCHELL: Member, once again I will use some terms that I know the member thinks we have not thought much about. We do not believe this amendment is necessary because clause 449 already enables the Mental Health Tribunal to arrange for a patient's representation at tribunal hearings. Part 21, which is quite large, covers a lot of this. Issues relating to legal representation are probably better dealt with in part 21. When we get to the legal representation—it will come up again—some patients may actually not want legal representation, but they will certainly have the ability to choose to have people there, whether it is a legal representative or someone else. We believe that what the member has asked for in this amendment is covered in clause 449.

Dr A.D. BUTI: I think it probably is not. We are talking about mandating something, and the parliamentary secretary said that the patient can decide whether or not they want legal representation. If that is the case, it is probably unlikely that an involuntary treatment order will be issued. If an involuntary treatment order was made, I think it would be on shaky ground if a patient had the capacity to decide whether or not they wanted legal representation. How could they have the ability to make a decision on whether or not they wanted legal representation if an involuntary treatment order was made? If they do make a decision, one would have to query whether they are making an informed decision. If the psychiatrist has imposed an involuntary treatment order, the person must be in a quite severe medical situation. One would query whether that patient would have the capacity to decide whether or not they wanted treatment. We are talking about mandating the necessity for legal representation to be arranged.

Ms A.R. MITCHELL: I think we are talking about different kinds of capacity here, and I will have to start cross-referencing from part 5, division 1, versus division 2 and things like that. As I said, we have given all the member's amendments serious consideration —

Dr A.D. Buti: You couldn't have, because I just drafted some today, so you haven't given them much consideration.

Ms A.R. MITCHELL: My advisers have been working with them since they received that information. As I said before, we do not believe the amendment is necessary. Also, I have just been advised that under clause 446 the tribunal can order that the person be represented if it is in their best interests.

Dr A.D. Buti: "Can" is not mandating.

Ms A.R. MITCHELL: But I am sure they would work towards that.

Ms S.F. McGURK: I am a bit unclear where exactly the parliamentary secretary is saying the bill states that people would be given proper representation. As the member for Armadale said, the idea that they could make a choice themselves about whether they require legal representation is a little absurd if they are in such a state that they have been made an involuntary patient. Could the parliamentary secretary be more specific about how someone will ensure that that person's legal interests are being looked after, and where the bill spells that out?

Ms A.R. MITCHELL: Member, all involuntary patients have access to a mental health advocate who can arrange for legal representation. We have supported the advocacy service generally so that it is available to people.

Ms S.F. McGurk: Is it mandated?

Ms A.R. MITCHELL: They have access to that, and it will be up to the advocates to determine what is best for that patient.

Dr A.D. BUTI: It is interesting that the parliamentary secretary mentioned the Chief Mental Health Advocate. We have moved a number of amendments to ensure that the Chief Mental Health Advocate is provided with information. Each time I have moved those amendments, the parliamentary secretary has not allowed that information to be transferred to the Chief Mental Health Advocate. The parliamentary secretary is saying that the Chief Mental Health Advocate will be the same as the current official visitor, but they do not always arrange legal representation.

Ms A.R. Mitchell: The role is expanded.

Dr A.D. BUTI: They do not always arrange legal representation. As I said previously, I talked with an official visitor who expressed major concern about information not flowing to them, and that some of the patients were scared to speak to them because they were told it would affect their ability to be granted leave from the hospital. It is a bit rich for the parliamentary secretary to say that the Chief Mental Health Advocate will arrange legal representation because every other time we have tried to give the Chief Mental Health Advocate the status that he should be receiving under this bill, the parliamentary secretary has not backed our amendments. She also stated today that all our amendments have been given careful consideration. They have probably been given as careful consideration as is possible by her advisers in the period that they have been aware of these amendments.

I am sure it is a mammoth job. I think the parliamentary secretary is under instruction not to accept any amendments. She moved amendments that followed on from the amendments that I moved but she still could not agree to the same wording; it had to be slightly different. She will not agree to any amendments, whatever their merits. That is the problem that we have. We should be working as a Parliament to present the best possible bill so that it can be passed and then considered and reviewed by the other house and eventually become the law of Western Australia. The parliamentary secretary refuses to allow us to improve this bill. Surely it is not possible that all wisdom on mental health resides on the government side of the chamber; I find that strange to believe. Some people on this side may have some ideas that will improve the bill. The parliamentary secretary's stubborn obstructionist attitude to any amendment that we have put forward is incredibly disappointing. We have been debating this bill for a long time because we seek to improve the bill—a major piece of legislation before this house.

Ms S.F. McGURK: I want to support what the member for Armadale has said not only with regard to the overall approach to efforts from this side of the house to improve the bill, but also on this point in particular. Someone is made an involuntary patient because they are that ill that they are not able to exercise their own physical will et cetera, so the state has to take control of them. That is how extreme this situation is. I am concerned that unless a specific provision can be pointed out in the bill, at the moment there is no capacity for someone to provide that person with legal advice and ensure that their rights are protected. If the mental health advocate is given some information, they may decide that that is appropriate but, as the member for Armadale pointed out, they will not necessarily have all that information before them. It is not mandated under this bill, unfortunately, in its current form. Perhaps they would have more information if the amendments that we on this side of the house put forward had been considered. Considering the extremity of the situation in which someone is made an involuntary patient, it seems all the more necessary that someone is looking after their legal interests and ensuring that no transgressions are occurring to the detriment of the patient.

Ms A.R. MITCHELL: The differentiation is in the words "must "or "may". Under this bill, all involuntary patients have access to a mental health advocate who can give advice. It is still the patient's choice. If the mental health advocate believes that they need legal representation, that will be provided. The bill unambiguously states that adults and children appearing before the Mental Health Tribunal may appear in person or be represented by another person. The tribunal may make an order in relation to another person, adult or child, requiring them to be represented if the tribunal is of the opinion that it is not in the patient's best interest to represent themselves. We are covering all areas. At this stage we do not support making it mandatory.

Ms S.F. McGURK: If the parliamentary secretary is covering all those areas, what is wrong with our proposed amendment? I find it absurd that she says that an involuntary patient has the capacity to decide whether they require legal representation. That is just farcical, frankly. The mental health advocate has the power that may require that the person is given legal advice or legal representation. Firstly, the word "may" is used, not "must"; and, secondly, it assumes that the mental health advocate has all the information that might be pertinent to this person's case before them. The member for Armadale has already pointed out a number of instances in which we think the bill is deficient in that regard. I cannot think of a case more serious than making someone an involuntary patient. If they are that ill and things are that dire for their health and safety or the safety of the people around them, that person is made an involuntary patient. They have not done anything wrong—perhaps they may do something wrong—yet they are being deprived of their liberty. It seems to me only logical that this legislation should require that they be given proper legal representation.

Dr A.D. BUTI: I would like to echo further the comments made by the member for Fremantle. Legislation is specifically written around the words "may" and "shall". They often become important words when determining whether the subject "may", "shall" or "can". It is only by using the word "must" that we are mandating. If we used the words "may", "shall" or "can", we are not mandating. It is just absurd. We are saying that someone under an involuntary treatment order has the capacity to decide whether they want legal representation. It is absurd that people under the criminal justice system who may have engaged in a brutal crime have more legal rights than a person with a mental illness.

By not obligating or mandating legal representation here, the parliamentary secretary is affording greater legal rights to murderers in Western Australia. A murderer would not have to stand trial without a lawyer. Legal Aid WA will provide a lawyer for a person who is charged with murder. Under this bill, a person has not committed a crime—presumably, they are mentally ill because they are under an involuntary treatment order—and the government is not mandating that they have legal representation. The Chief Mental Health Advocate will always have the capacity to arrange appropriate legal representation. This amendment is saying that a guardian should be appointed for the purpose of arranging legal representation. This is necessary to ensure that the person with an involuntary treatment order is awarded and afforded appropriate legal representation. To say that they have the capacity to make an informed decision on whether they want legal representation would be laughable if it was not serious. It is an absurd proposition. For the parliamentary secretary to bring in the Chief Mental Health

Advocate to whom she has not afforded the same status as other people under the bill at this late stage is also incredibly disingenuous and shows that she is here to do nothing but ensure that the bill presented to this house by the Minister for Mental Health from the other house is not changed by the opposition at all. It is absolutely quite disgusting.

Ms A.R. MITCHELL: I have been informed that quite often involuntary patients have been made involuntary because of their inability or incapacity to understand treatment and things like that, but it does not mean that they do not have the capacity to make decisions.

Dr A.D. Buti: Not all of them!

Ms A.R. MITCHELL: No. I am just saying that the member has made an assumption that all involuntary patients are in the same category, when it is not exactly true. Some patients actually want the mental health advocate; they want non-legal advocacy. They might want a carer or the person they have selected as their nominated person. To impose legal representation on every patient can also mean taking away the patient's choice as well. So it is open, but it is certainly available and encouraged to be used, if people want it.

Dr A.D. BUTI: The parliamentary secretary says that some people who are under the involuntary treatment order still have the capacity to decide whether they want legal representation. It may be the case, but there would be, I reckon, a pretty significant proportion of people who do not have that capacity. There may be some people under an involuntary treatment order who say they do not want to be a patient, which is a symptom of the fact that they are under an involuntary treatment order. I am sure there are many people who have a mental illness who do not want any help. That is one of the reasons the government has given them an involuntary treatment order because they do not want that medical help. So it is okay there, is it? It is okay to impose a medical treatment on an involuntary patient—that is okay, but at the same time the parliamentary secretary says it is okay for them to be denied legal representation! How absurd can she be—how absurd! She will take away people's right to decide whether they want treatment or not, but she will not ensure that they have the ability that is mandated to receive legal representation. That is absolutely absurd.

It shows that the objects of this bill are an absolute farce because the provisions of this bill, time and again, do not comply with the objects. We have sought to move a number of amendments that will seek to improve the compliance of this bill with the objects, but every time we have, the parliamentary secretary has resisted. Many times she has resisted for an irrational, illogical position without any evidence to back her obstructionist position.

Ms S.F. McGURK: I will make one final point, and I think the member for Armadale has expressed the frustration. There could not be a more worrying case than when someone has been ordered to be an involuntary patient because of their reputational risk. Considering that, our concern is that the order could be of a subjective nature. The point has been made again by the member for Armadale and others that it is the ultimate irony; namely, if nothing else will put someone's reputation at risk, it would be being made an involuntary patient. But having said that, that is a very subjective judgement, and it seems completely reasonable and, in fact, necessary that someone would be given professional advice about whether that is in their interests and is complying with the act. That is neither a patient's view about whether that was complying with the act and is legal, nor the view of their guardian or carer; it is a professional legal person's view. That is a lawyer's view that the act was being complied with in that case and therefore is a case of reputational damage.

The particular provision I am talking about, as I said, is a very subjective view, which is what our concern is about; that is, the orders for being made an involuntary patient are made in those circumstances. So let the record be clear that we have some real concerns that patients' rights are significantly diminished by there being no mandated requirement that they be given legal representation in the case of an order being made to become an involuntary patient.

Division

New clause put and a division taken, the Acting Speaker (Mr N. Morton) casting his vote with the noes, with the following result —

Ayes (15)

Ms L.L. Baker	Mr F.M. Logan	Mr P. Papalia	Mr C.J. Tallentire
Dr A.D. Buti	Mr M. McGowan	Mr J.R. Quigley	Mr P.C. Tinley
Mr R.H. Cook	Ms S.F. McGurk	Mrs M.H. Roberts	Mr D.A. Templeman *(Teller)*
Mr D.J. Kelly	Mr M.P. Murray	Ms R. Saffioti	

Noes (30)

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

Pairs

Ms J. Farrer	Ms W.M. Duncan
Mr W.J. Johnston	Mr T.R. Buswell
Ms J.M. Freeman	Dr G.G. Jacobs
Mr P.B. Watson	Mr J.E. McGrath

New clause thus negatived.

Clause put and passed.

Clause 248: Right to access medical record and other documents —

Dr A.D. BUTI: This is a clause that gives the patient the right to access medical records and other documents; but, of course, there are some restrictions under clause 249. Besides the exceptions or restrictions under clause 249, does clause 248 give an absolute right of access to medical records? If so, it would overrule the High Court of Australia decision of Breen v Williams—which we can do, under legislation. Breen v Williams was, of course, the decision of the High Court that the property of the medical records is with the medical practitioner, and therefore they have that right. I am glad that the patient has that right, but I just want to make clear that the legislation is intended to overrule the High Court case of Breen v Williams.

Ms A.R. MITCHELL: I am advised that this legislation prevails over common law, and —

Dr A.D. Buti: Yes, I know that. Thank you; I did say that. I wanted you to state clearly that that's what you're intending to do.

Ms A.R. MITCHELL: I know, I am stating that, and we have this clause in the bill.

Dr A.D. BUTI: I thank the parliamentary secretary. I think I kind of did know that legislation overrules common law; I thank the parliamentary secretary for informing me of that. I just wanted to place on record that that is the intention. The legislation does seem to overrule Breen v Williams. What I want recorded in *Hansard* is that that is the intention. The overruling may be a consequence of the clause, but I want to know whether that is what is actually intended—to overrule Breen v Williams. There is nothing wrong with overruling it; I just want that placed on the record.

Ms A.R. MITCHELL: Subject to clause 249, yes.

Clause put and passed.

Clauses 249 to 252 put and passed.

Clause 253: Duty not to ill-treat or wilfully neglect patients —

Ms S.F. McGURK: I do not have an amendment, just a question or clarification relating to the penalties applying under clause 253 in respect of the ill-treatment or wilful neglect of patients. I know that this matter has been raised by a few different groups; the maximum penalties are a fine of up to $15 000 and imprisonment for two years. However, if we look at the penalties for offences against animals under the Animal Welfare Act, we see that the maximum penalties for cruelty are a fine of $50 000 and imprisonment for five years. Was consideration given to how insulting those comparative penalties might be to mental health patients and their families?

Ms A.R. MITCHELL: The sanctions in this legislation for wilfully neglecting or ill-treating a patient have been doubled, from one to two years' imprisonment, which was in line with the recommendations of the Holman review. That was taken as a good place from which to start, and it is my understanding that this maximum sentence is in line with similar penalties in other jurisdictions. That is how the comparisons have been brought together for the Mental Health Bill, rather than referring to the Animal Welfare Act.

Ms S.F. McGURK: Does the parliamentary secretary understand the offence that will be taken by mental health patients and their families when they learn that the penalties for offences against animals are greater? I have no objection at all to there being significant penalties against people who are convicted of cruelty to animals, but there is a big difference between the maximum penalties that apply under the Animal Welfare Act—a $50 000 fine and five years' imprisonment—and this legislation, which is a $15 000 fine and two years' imprisonment. It really does beggar belief that that was pointed out to the government, yet those penalties have remained the same, and in such stark contrast. I do not know who is lobbying the government on this point but, as I said, in this case I do not think it is mental health patients or their families; this could be hurtful at best, but is more likely to be insulting to patients and their families.

Ms A.R. MITCHELL: It certainly has not come up in any consultation that has taken place since the Holman review. There was certainly consultation at that time with carers and consumers. The matter has not come up since that time in any of the processes of developing this legislation through the draft bills, and it has been accepted.

Ms S.F. McGURK: It was raised with us in briefings we had from members of the Mental Health Law Centre; they actually pointed it out to us. We were given a breakdown of their concerns, which were numerous. They had some supportive things to say about the bill, but they also had a number of concerns, some of which have been mirrored in the amendments proposed by the member for Armadale and other members on this side of the house. I find it a little strange, and very difficult to believe, that the Mental Health Law Centre did not raise this matter with the government also. This certainly has attracted some concern in my electorate, obviously in respect of the Alma Street clinic and the clinic at Fremantle Hospital. There is quite a bit of local debate about how mental health patients are cared for, what resources are made available to them and the regulatory circumstances in which they are cared for. This particular comparison drew a lot of concern in my electorate. I find it difficult to defend, and I am interested to know how the government could have done it; so far I have not heard any explanation or defence. I do not think that that comparison is acceptable.

Ms A.R. MITCHELL: The only group that has made contact with the Mental Health Commission on that issue, and then only recently, is the Mental Health Law Centre. I think the member for Mirrabooka raised it in her contribution to the second reading debate. That was the only time that I heard it.

Ms S.F. McGurk: I raised it as well.

Ms A.R. MITCHELL: As I said, the sanctions that have been imposed came out of the Holman review. In fact, they were doubled. That was consulted on widely and that is how the decision has been made. I will be honest: it is my understanding that the Animal Welfare Act was not considered in the drafting of this bill, because we were working on the concerns that people had spoken to us about, and they did not raise that concern in the initial consultation.

Dr A.D. BUTI: The point made by the member for Fremantle goes to the value that we afford mentally ill patients. Are a $15 000 fine and imprisonment for two years sufficient penalties for the ill-treatment or wilful neglect of some of the most vulnerable people in our society? The member for Fremantle contrasted the situation with that of animals. I love animals. I love my dog. I am glad those penalties are in force. I am sure all dog lovers are very happy about that. However, it really is an affront to mentally ill people and their families that we have a situation in which the penalties that apply in their regard are quite lenient in many respects compared with the penalties that we have decided as a Parliament and a society to have in place for animals. Thank goodness we do have them with regard to animals, but, gee, should we not also have them for offences involving people who are mentally ill?

Clause put and passed.

Clause 254: Duty to report certain incidents —

Dr A.D. BUTI: This clause states —

> (1) In this section —
>
> ***reportable incident***, in relation to a person, means —
>
> (a) unlawful sexual contact with the person by a staff member of a mental health service; or
>
> (b) the unreasonable use of force on the person by a staff member of a mental health service.

That is fine. It goes on —

> (2) A staff member of a mental health service who reasonably suspects that a reportable incident has occurred in relation to a person for whom the Chief Psychiatrist is responsible under

section 512(1) who is being provided with treatment or care by the mental health service must report the suspicion to —

(a) the person in charge of the mental health service; or

(b) the Chief Psychiatrist.

Nowhere in that clause is it mandated that the police be notified. Nowhere in that clause is it mandated that there is a duty to report it to the police. That is ironic when we are in the middle of a royal commission into institutional child abuse. What has come through that royal commission day in and day out is the failure of people in authority to report allegations, suspicions or actual incidents of sexual abuse to the authorities. As we know, a lot of psychological and sociological studies have been done into institutional loyalty. Will the Chief Psychiatrist be the judge and jury here? If a staff member has a reasonable suspicion that a reportable incident has occurred and reports that to the Chief Psychiatrist, are we saying that it will be up to the Chief Psychiatrist to determine whether that matter is reported to the police? I challenge the parliamentary secretary and her advisers to find me a word in that clause that mandates that the Chief Psychiatrist has to report a reportable incident to the police. I cannot find it. Is that not absurd? The penalty is a $6 000 fine. That is fine, but it is still not mandated that the matter be reported. Who do they report it to anyway? The $6 000 fine is not for not reporting it to the police. From my reading of the clause—it is late in the afternoon so I may not be reading it correctly—the penalty will be imposed if a reportable incident is not reported to the person in charge of the mental health service or the Chief Psychiatrist. There is no fine if a person does not report it to the police or if the Chief Psychiatrist does not report it to the police. I think that is an incredible failure of that clause.

Ms A.R. MITCHELL: I would like to reassure the member that this requirement is in addition to other written laws, such as the laws around the mandatory reporting of child sex abuse and the Health Practitioner Regulation National Law (WA) Act, so there are three areas actually working —

Dr A.D. Buti: But the child might be an adult.

Ms A.R. MITCHELL: There are laws in place. There is the Health Practitioner Regulation National Law (WA) Act. There will be more in the clinicians' guide as well. We did not necessarily enshrine it in the bill because it is in those other forms as well, which will be demonstrated through the clinicians' guide.

Dr A.D. BUTI: In the way the clause is written it only mandates that the report be made to the Chief Psychiatrist. It will then be up to the Chief Psychiatrist to decide whether to report it. The Chief Psychiatrist might determine that there is not a reasonable suspicion, that the person involved is a valued staff member or that it was not major unlawful sexual contact. The Chief Psychiatrist is the gatekeeper. I cannot understand why, in a clause that outlines a duty to report certain incidents, that duty would not also require a reporting of the matter to the police. I think that the Chief Psychiatrist has an obligation to report every incident that is brought before them to the police. The clause does not even state that if the Chief Psychiatrist determines that it is a legitimate complaint, it has to be reported. This clause does not place a duty on the Chief Psychiatrist to do anything. Nothing in that clause is about the Chief Psychiatrist needing to do anything with that information.

Ms A.R. Mitchell: But health practitioners have to comply with the laws of the land as well.

Dr A.D. BUTI: Of course they have to comply with the laws of the land, but if this bill is going to include a provision about the duty to report reportable incidents, why is the duty to report only to the Chief Psychiatrist? Why is there not a duty to report it to the police? That is where the duty should be. As I said to the parliamentary secretary, there is a royal commission at the moment into institutional child abuse. Loyalty to an institution can be incredibly strong. The bill should include the necessity that the incident be reported directly to the police or that the Chief Psychiatrist or the person in charge of the mental health service has the obligation to report it to the police.

Ms A.R. MITCHELL: This clause deals with suspicions. Quite often those suspicions need to be investigated a little before they are reported to the police. The police will obviously be involved when there is a place for that. It does not have to be the Chief Psychiatrist; any staff member, any person in charge of a ward or anyone can report it to the police. We are not precluding that. It is the way it is done.

Dr A.D. Buti: It is referring to more than a suspicion. It refers to unlawful sexual contact, not just suspicion. Suspicion comes under subclause (2).

Ms A.R. MITCHELL: Anyone can report at any time. They are both mentioned there.

Ms S.F. McGURK: I, too, find it a little hard to believe that there would not be a mandatory requirement to report to the police a suspicion of criminal conduct or unlawful sexual conduct. It may be that there are codes of conduct or there is other legislation that requires that to be the case. However, in this instance, we talking about how the Chief Psychiatrist and the people who operate under the domain of the Chief Psychiatrist deal with

incidents in which they believe there has been unlawful sexual conduct or unreasonable use of force by a staff member of a mental health service. As the member for Armadale pointed out, there has been a lot of public attention about this matter in the last few years, and at the moment in particular through the Royal Commission into Institutional Responses to Child Sexual Abuse. Although we find those responses abhorrent and difficult to believe, we also need to learn from what occurred in those instances and make sure our legislation provides as many safeguards as possible. We need to make it absolutely clear to the Chief Psychiatrist and to the people to whom the Chief Psychiatrist may delegate, and to staff of a mental health service, what their requirements are. The government should therefore look at making an amendment to clause 254 to provide for the mandatory reporting to police of suspected criminal behaviour, in this instance unlawful sexual conduct, or the unreasonable use of force, by staff of a mental health service.

Dr A.D. BUTI: Can the parliamentary secretary please outline to me where in law there is a provision that makes it an offence for the Chief Psychiatrist not to report to the police a suspicion of unlawful sexual contact? While the parliamentary secretary is thinking about that, I would ask her to please not refer to any codes of conduct. I am talking about the law. That is an incredibly important question, and I would like an answer. In the parliamentary secretary's response to me previously, she said that the law mandates that the Chief Psychiatrist would report. I would like the parliamentary secretary to tell me what law requires the Chief Psychiatrist to report.

Ms A.R. MITCHELL: I did refer to the Health Practitioner Regulation National Law. That lists mandatory notifications.

Dr A.D. Buti: What does it say?

Ms A.R. MITCHELL: I do not have it all in front of me. There is also the Australian Health Practitioner Regulation Agency, which is quite specific, along with our other laws. The Chief Psychiatrist, and Dr Patchett, who is sitting beside me, have said that the first people they would call are the police.

Dr A.D. Buti: What was that? Can you repeat that?

Ms A.R. MITCHELL: Dr Patchett has informed me that they call the police quite regularly.

Dr A.D. Buti: I am not making an accusation that they do not do that.

Ms A.R. MITCHELL: There are also regulations that they operate under, and those regulations have been in operation for a long period and will continue to be in operation. I understand the member's concern, but I think it is covered.

Dr A.D. BUTI: I do not think that once in my representations on this clause have I said that psychiatrists do not report allegations of unlawful sexual conduct. What I am asking is: where is it mandated that they must report that? The parliamentary secretary has referred to regulations. Are they commonwealth regulations; and, if they are, what authority do they have in respect of psychiatrists who are employed by our state body; how do those regulations interact with the state's criminal laws; and what are the penalties if people do not comply with those regulations?

Ms A.R. MITCHELL: Member, I apologise if I was not clear. It is a national law, and it is given force in our act, the Health Practitioner Regulation National Law (WA) Act 2010.

Dr A.D. BUTI: What is the penalty if people do not comply with the reporting requirements? What does that act state about reporting? What is the actual wording of the section?

Ms A.R. MITCHELL: I do not have all that information in front of me, but I am told it is covered in section 141 of that act, and the act also prescribes the penalties.

Dr A.D. BUTI: That is fine. Clause 254 refers to a duty to report certain incidents. Under that clause, there is no obligation to report to the police. We are also told by the parliamentary secretary that there is a national law that has effect in Western Australia, due to a certain act, and there is a section in that act that refers to mandatory reporting. We do not know exactly what the wording of that section is. We do not know whether there is any exemption or any defence if people do not report an incident because they have the honest and reasonable belief that the allegation is not based on merit or a factual scenario. We are told that there is some sort of penalty. It might be a fine that is less than $6 000. We are told that we should take that on face value, and we do not need to worry that clause 254 does not mandate reporting to the police, because there is other legislation that deals with that. It is pretty hard for us to form an opinion on that other piece of legislation when the parliamentary secretary does not have the capacity to tell us what that piece of legislation provides. It is absurd that we are talking about a duty to report certain incidents, but that does not include a duty to report to the police. All this clause is telling us is that the incident has to be reported to the Chief Psychiatrist or the person in charge of the mental health service. They become the gatekeepers. Under this clause, the penalty applies only to a staff member who does

not report, I presume. There is no penalty for the Chief Psychiatrist or the person in charge of the mental health service if they do not do anything with that allegation or report. That is absurd.

Clause put and passed.

Clauses 255 to 261 put and passed.

Debate adjourned, on motion by **Mr J.H.D. Day (Leader of the House)**.