MENTAL HEALTH AMENDMENT BILL 2015

Introduction and First Reading

Bill introduced, on motion by **Hon Helen Morton (Minister for Mental Health)**, and read a first time.

Second Reading

HON HELEN MORTON (East Metropolitan — Minister for Mental Health) [4.01 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 received royal assent on 3 November 2014 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 is to section 4, 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. Further, an involuntary treatment order can only be made by a psychiatrist. A medical practitioner should only have the power to make an involuntary treatment order 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, which 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 the United Kingdom, Ireland and Canada.

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 but are not yet ready to be tabled. However, it is intended that the relevant regulation will refer to a medical practitioner who holds a qualification that both the Royal Australian and New Zealand College of Psychiatrists and the Medical Board of Australia deem to be substantially equivalent, or based on similar competencies, to a qualification required to competently and safely perform the functions of a Fellow of the College of Psychiatrists. Both the board and the College of Psychiatrists have strict, standardised and transparent processes for determining whether or not a medical practitioner is competent to practise as a psychiatrist. Only those psychiatrists who have a rigorously assessed qualification will fall within the scope of the definition.

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 need to change in the future. Therefore, I am proposing that that 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 any necessary amendment 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 a 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 46 new authorised beds at the new St John of God Midland Public Hospital mental health unit in November would be at risk. Because of the difficulties 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 will be 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. Removal of the word “authorised” from section 186 is intended to remove any confusion as to whether or not a treatment, support and discharge plan is required with respect to an involuntary inpatient in a general hospital. Amendment of section 420 will remove the word “therapy”, which was inadvertently included and is superfluous in context. Section 591(3) refers to the Public Sector Management (Redeployment and Redundancy) Regulations 1994. The Public Sector Management (Redeployment and Redundancy) Regulations 2014 came into operation on 1 May 2015. The proposed amendment would refer to the current regulations. Finally, a cross-reference in section 592 needs to be corrected to substitute reference to section 520(5) with subsection (6).

Pursuant to Legislative Council standing order 126(1), I advise that this bill is not a uniform legislation bill. It does not ratify or give effect to an intergovernmental or multilateral agreement to which the government of the state is a party, nor does this bill by reason of its subject matter introduce a uniform scheme or uniform laws throughout the commonwealth.

I commend the bill to the house and table the explanatory memorandum.

[See paper 3507.]

Debate adjourned, pursuant to standing orders.

Sitting suspended from 4.12 to 4.30 pm