**MENTAL HEALTH BILL 2013**

*Consideration in Detail*

Resumed from an earlier stage of the sitting.

**Clause 354: Directions to Chief Mental Health Advocate to report on particular issues —**

Debate was interrupted after clause 353, as amended, had been agreed to.

**Clause put and passed.**

**Clauses 355 to 371 put and passed.**

**Clause 372: Conflict of interest —**

**Dr A.D. BUTI**: Division 4 deals with other matters relating to mental health advocates. This clause deals with conflicts of interest, which we have dealt with on a number of occasions throughout the consideration in detail stage. There are some issues with conflicts of interest that I want to talk about. I note that clause 372 states —

> (1) A mental health advocate may be employed by, or have a disqualifying interest under subsection (3) in, a body or organisation that provides treatment or care for identified persons.
>
> …
>
> (3) For subsection (1), a mental health advocate has a disqualifying interest in a body or organisation if —
>
> (a) the mental health advocate; or
>
> (b) another person with whom the mental health advocate is closely associated,
>
> has a financial interest in the body or organisation other than a financial interest prescribed by the regulations for this subsection.

Of course, regulations will come at a later stage, but the same level of scrutiny will not apply to them.

**Mr P. Abetz**: We do a good job on the delegated legislation committee.

**Dr A.D. BUTI**: I hope the member does. Can the parliamentary secretary give an example of what sorts of regulations will be prescribed to deal with financial interests?

**Ms A.R. MITCHELL**: Obviously, the drafting of regulations has not commenced yet, but they will be drafted in consultation with the mental health sector, as has occurred throughout this whole process.

**Dr A.D. BUTI**: I understand; of course they have not been drafted yet. However, there must be some indication of what financial interests will be prescribed by regulations that the parliamentary secretary is aware of. There must be some understanding of that at this stage.

**Ms A.R. MITCHELL**: They have not been started yet and they will be done in conjunction with the mental health sector so that all aspects are considered.

**Dr A.D. BUTI**: We are being asked to support a clause that includes regulations in which the government at this stage has no idea about what financial interests may be prescribed, which is rather disconcerting. Anyhow, in regards to conflicts of interest, as the parliamentary secretary will recall, we have had quite a number of exchanges on the removal of a provision from an earlier 2011 draft of this bill whereby the medical practitioner had to disclose financial interests or relationships that they may have had. That was removed, but the government feels that the financial interests of mental health advocates are important. The parliamentary secretary may say to me that the financial interests of the treating psychiatrist or practitioner are important; they may be important, but the government does not require them to disclose those financial interests to the patient who therefore cannot give informed consent. Why is there a clause here dealing with the need to consider the financial interests of a mental health advocate in regards to a conflict of interest, but no requirement for the disclosure by the medical practitioner of their financial interests?

**Ms A.R. MITCHELL**: As we have said a number of times on this issue, the medical practitioners have a code of practice that they need to comply with, and there are some serious consequences if they do not. The mental health advocates do not have such a code and that is why this provision is in the bill.

**Dr A.D. BUTI**: The point is that the parliamentary secretary also said that the Australian Medical Association said that the financial disclosure provisions should be removed, even though it has a code of practice that requires financial disclosure. I know it has a code of practice that requires it and that it is also one of the stipulating provisions of mental health review boards in Australia. It is absurd to go to the extent here of quite a

comprehensive clause in regard to conflicts of interest for mental health advocates and not to have that same legislative enactment in respect of treating doctors. The parliamentary secretary says that it is covered by the doctors' code of conduct. It may be covered by a code of conduct and there may be serious consequences if they do not comply with that—they may be deregistered or there may be some other professional sanction—but it does not have legislative force, and it does not necessarily provide the patient with the same degree of remedial solutions that there would be if there was a legislative provision. I will say this again because I am really concerned that the financial disclosure regulation in regards to medical practitioners is not included in this bill. There is very clear legal doctrine on all conflict of duty and conflict of position—it is very, very clear. That means that there cannot be a conflict between the doctor's duty to the patient and any financial position or other interest the doctor may have. By not stipulating that in the legislation, the positive legislative obligation of the medical practitioner to disclose that information is removed. There may be a professional obligation, but a professional obligation does not have the same status as a legislative obligation. The member's answer to my question was that the provision for mental health advocates was included because medical practitioners have that provision under their code of conduct. Surely, a code of conduct could be established for mental health advocates. I think it would be quite prudent to have a code of conduct for mental health advocates. Most advocate services do have codes of conduct, so why would there not be one for mental health advocates? If that was the case, the financial interest provision would be put in that code of conduct. The government has seen it as important to include a legislative provision for mental health advocates in regards to conflicts of interest for financial matters. That is the way it should be, even though we have been talking about regulations that are not known at this stage, but there is no such provision for practitioners who will be the pre-eminent player in determining what treatment someone receives. The mental health advocate is just there to advocate on behalf of the patient; they do not recommend the treatment. Why is there this provision for mental health advocates but not for medical practitioners when it goes against a long line of legal precedents? The parliamentary secretary's only justification is that the medical practitioner has a code of conduct and the mental health advocate does not.

**Ms S.F. McGURK**: I am interested in what the member has to say.

**Dr A.D. BUTI**: I am very glad that the member for Fremantle is interested in what I am saying!

I was talking about this issue to a friend of mine who is an orthopaedic surgeon, and he was absolutely aghast that the government is introducing legislation having removed a previous draft provision in regards to financial disclosure. He was saying that the Royal Australasian College of Surgeons has a very strong onus on disclosure of financial interests, and to have a legislative reinforcement of that is incredibly important, because as the medical profession develops, there is a vertical integration. For instance, orthopaedic surgeons often perform operations and they have a financial interest in the equipment that they use as well is in foreign objects that may be inserted into the body as a result of the operation. There is no reason why vertical integration will not become more prominent in psychiatry. As we know, the former member for Bassendean has highlighted psychiatrists who have had financial interests in research or pharmaceutical companies that they then support by the way they advocate medication for patients. I just do not understand why there is a provision for the conflict of interest in regards to the financial interests of mental health advocates, but that legislative provision is not included for treating practitioners.

**Ms A.R. MITCHELL**: The code of practice for medical practitioners comes under the Health Practitioner Regulation National Law (WA) Act and it is administered by the Medical Board of Australia. The mental health advocates have no such recognised professional code of ethics or conduct, and hence the provision in clause 372.

**Clause put and passed.**

**Clause 373: Delegation by Chief Mental Health Advocate —**

**Dr A.D. BUTI**: I will not spend long on this clause regarding delegation by the Chief Mental Health Advocate. Once again, clause 373(4) stipulates the power or duty to delegate. I see that as a problem, but I think I made my point about that issue regarding the director. The ability for mental health advocates to allocate their duty—that is, their legal obligation—is a very worrying aspect of this clause, and they should be able to allocate their exercise or operational matters, not their legal liability.

**Clause put and passed.**

**Clauses 374 to 377 put and passed.**

**Clause 378: Terms used —**

**Dr A.D. BUTI**: We now move to part 21, "Mental Health Tribunal". Clause 378 defines the terms utilised in this part. I move —

> Page 272, lines 7 and 8 — To delete "direction or declaration" and insert —
>
> direction, declaration or recommendation

It is probably quite obvious why I wish to add "recommendation". Recommendations can be powerful directives or orders. Although they may not have the mandatory consequence that a direction or declaration has, they are important, as recommendations are often followed. It is important that the tribunal has the ability to look at recommendations, because if a recommendation is taken up, it will have the same force as a directive and maybe a declaration.

**Ms A.R. MITCHELL**: The government believes there is a significant difference. Recommendations do not have a binding force. They are important but substantively different from binding decisions. The government does not believe that recommendations should be added to the definition of "decision", which is also binding.

**Dr A.D. BUTI**: The parliamentary secretary is correct that recommendations do not have the binding nature of a directive. Then again, what is a declaration? A declaration is usually a pronouncement on an existing legal status. That is all it is. A declaration often does not lead to anything. A declaration states the existence or status of something. A recommendation may lead to something. Granted a recommendation is different from a directive, because a directive in many cases has a mandatory consequence—that is, if the directive is given that power under the bill—but not all directives have a mandatory effect. A declaration does nothing, but declares or pronounces the existence of a certain status or right, whereas a recommendation may end up having the same consequence as a directive; therefore, the tribunal should have the ability to review a recommendation. My amendment will give the Mental Health Tribunal the jurisdiction to examine or deal with issues that have a recommendation attached to them. More often than not, a recommendation will be put in place because of the power of the people who are making the recommendation. In all respects, it is more important for the Mental Health Tribunal to have the ability to review recommendations than to review declarations.

**Ms A.R. MITCHELL**: I am not sure what experience the member has in this area, but in the jurisdiction of the Mental Health Tribunal a "declaration" has mandatory consequences.

**Dr A.D. Buti**: In what way?

**Ms A.R. MITCHELL**: I refer the member to a declaration order in clause 397, to clause 398 for the consequences of declaring a treatment order invalid and also to clause 428 for a declaration about the validity of a nomination. The bill sets out quite definitively the way in which the word "declaration" is used in this bill.

**Dr A.D. BUTI**: Clause 397, "Declaration about validity of treatment order", goes to the legality or the validity of something; it does not necessarily have a mandatory aspect to it. It may end up stopping something that is invalid, but it is just stating something. If it is valid, it is valid. If it is invalid, it will stop. However, a recommendation will often be put in place also. This amendment seeks to give the Mental Health Tribunal jurisdiction to consider issues in regard to recommendations. The objects of the bill are set out in clause 10—that is, to ensure that the rights and freedoms of patients are infringed in the least possible way to ensure their safety and the safety of the community. If the government wants to ensure that the Mental Health Tribunal is doing its appropriate job, why would the government have a problem with the tribunal having the jurisdiction to look into recommendations?

**Ms A.R. MITCHELL**: Declarations have mandatory consequences under this bill, and clause 468 indicates what gives them a binding force.

**Dr A.D. BUTI**: Clause 468 deals with decisions, not necessarily declarations.

**Ms A.R. Mitchell**: A decision does include a declaration.

**Dr A.D. BUTI**: A decision is not necessarily a declaration; it could be a decision regarding the directive. In any case, even if it is, often it is a declaration under existing law. My amendment does not ask the parliamentary secretary to remove "declaration" from the jurisdiction of the Mental Health Tribunal, and I hope she will not! My amendment seeks to give the Mental Health Tribunal jurisdiction over recommendations. The parliamentary secretary referred to decisions under clause 468. Declarations are given a status equivalent to that of a decision, because clause 378 determines that a decision includes an order, direction or declaration. That is fine, but a declaration is often just a pronouncement on the existing law, and I understand that it can have mandatory consequences. Regardless of whether a recommendation has a mandatory status attached to it or not, rather than being too caught up in the terminology, what is more important are the consequences for the person or the patient who will come under the jurisdiction of the Mental Health Bill. For that, I go to clause 10, which refers to ensuring that their rights and freedoms are not infringed, respecting their dignity and ensuring they have proper treatment et cetera. Therefore, when something is recommended, the person making the recommendation hopes that it will be acted upon. Although it may not have a mandatory status attached to it, it is hoped that it will be acted upon, and often it will be acted upon. So I repeat: why can it not come under the jurisdiction of the Mental Health Tribunal? The Mental Health Tribunal will more than likely not review it if it is not acted upon. If the

recommendation is acted upon, the tribunal is more likely to look at it. If it is not acted upon, the tribunal is less likely to look at it.

**Ms A.R. MITCHELL**: I repeat again that we do not support the inclusion of "recommendation" because these do not have a binding force.

**Dr A.D. BUTI**: I think that is a very churlish response to this amendment. We are trying in this Parliament to ensure a proper legislative framework for the protection of people with a mental illness, instead of just saying that because something is not mandatory, we do not think the Mental Health Tribunal should be concerned about having jurisdiction over the matter. To me, that throws doubt on the government's commitment to complying with the express purposes of the Mental Health Bill 2013, as pronounced in clause 10. We strongly believe that the enactment of this bill should protect the rights, freedoms and dignity of patients, as stated in clause 10. That is why I moved this amendment.

**Ms A.R. MITCHELL**: The tribunal makes the recommendation, and that becomes the decision and the declaration. As to bringing things forward in that jurisdiction, the others do not have the ability to do what the member was saying. The Mental Health Tribunal makes the recommendation.

*Division*

Amendment put and a division taken, the Deputy Speaker (Ms W.M. Duncan) casting her vote with the noes, with the following result —

Ayes (15)

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

Noes (31)

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

Pairs

| | |
|---|---|
| Ms J. Farrer | Mrs L.M. Harvey |
| Mr M. McGowan | Dr K.D. Hames |
| Mr P.C. Tinley | Mr T.R. Buswell |
| Ms M.M. Quirk | Dr G.G. Jacobs |
| Mr W.J. Johnston | Mr B.J. Grylls |
| Mr P.B. Watson | Mr C.J. Barnett |

**Amendment thus negatived.**

**Clause put and passed.**

**Clauses 379 to 381 put and passed.**

**Clause 382: Constitution generally —**

**Ms A.R. MITCHELL** — by leave: I move —

Page 273, line 18 — To delete "involuntary".

Page 273, line 20 — To delete "involuntary".

I move these amendments to correct a drafting oversight reference. The reference to the involuntary patient in clause 382 is inappropriate, because not every tribunal hearing will relate to an involuntary patient; they could apply to a voluntary patient as well.

**Amendments put and passed.**

**Clause, as amended, put and passed.**

**Clauses 383 and 384 put and passed.**

**Clause 385: Initial review after order made —**

**Dr A.D. BUTI**: This clause deals with, basically, the periodic review while the order is in force. We have concerns about the need for a continuing treatment order to be in place in regards of the review period. We believe its continuity as a requirement for the review of involuntary treatment orders should be removed from the Mental Health Bill 2013. I wish to move, en bloc if possible, the first two amendments standing in my name under clause 385.

Leave granted.

**Dr A.D. BUTI**: I move —

> Page 275, lines 21 to 24 — To delete the lines.
>
> Page 276, after line 9 — To insert —
>
> and
>
> (c) there is no new relevant evidence or change in the circumstances regarding the patient's detention.

As I stated in my introductory comments to moving those amendments, the concern is regarding the continuity requirement in this bill.

**Ms A.R. MITCHELL**: I will refer to notes so that I get this correct. Deleting clause 385(4) would oblige the tribunal to calculate the time frame for an initial review based on the date of an earlier order, not the current order, even if the earlier order lapsed or was revoked months previously. This would mean that reviews would often need to be conducted immediately upon the making of an order before the treatment has the opportunity to take effect, and before the treating team is able to make informed assessments about the person's prognosis. Clause 387 prevents a person being made voluntary for a brief period in order to avoid the need for a review, and it is an important safeguard that would prevent the use of clause 385(4). Clause 385(4) relates only to mandatory scheduled reviews. It does not prevent the patient or a support person applying for a review at any time.

In regard to the second amendment, which we have agreed to look at en bloc, clause 385(5) merely clarifies that a person should not receive two automatic initial reviews if their involuntary status is only briefly interrupted. In such situations, the second review is more appropriately regarded as a periodic review. Clause 389 enables the patient or their support persons to apply for a review if they believe that there has been a material change in circumstances since the previous review.

**Dr A.D. BUTI**: I understand what the parliamentary secretary has said, but our concern is that by having the provision as it currently stands, the tribunal will not review many involuntary treatment orders that it otherwise would and should review under our amendment, which is why we believe that that amendment should be there. However, that is the parliamentary secretary's position and we will leave it at that.

**Ms A.R. MITCHELL**: We do not believe that that is the case, which is why we will not support the amendment.

**Amendments put and negatived.**

**Dr A.D. BUTI**: I seek your guidance, Madam Deputy Speaker. On page 13 of the notice paper, the second amendment to clause 385, which relates to page 277 —

**Ms A.R. Mitchell**: Do you mean that it deals with clause 386?

**Dr A.D. BUTI**: Exactly; that is why I was seeking guidance.

**The DEPUTY SPEAKER**: That amendment applies to clause 386, so I will put clause 385.

**Clause put and passed.**

**Clause 386: Periodic reviews while order in force —**

**Dr A.D. BUTI**: I move —

> Page 277, lines 24 to 27 — To delete the lines.

Subclause (4) states —

> The Tribunal is not required to review the order under subsection (2) if the involuntary patient has not, under section 387, been an involuntary patient continuously since the last review day.

Subclause (2) refers to the issue of the prescribed number of days et cetera. We strongly believe that periodic reviews should take place as much as possible, especially for involuntary patients.

**Ms A.R. MITCHELL**: Our same arguments apply for this amendment because these are only periodic reviews; the other one is for an initial review. So our same arguments apply.

**Amendment put and negatived.**

**Clause put and passed.**

**Clauses 387 to 393 put and passed.**

**Clause 394: What Tribunal may do on completing review —**

**Dr A.D. BUTI**: Clause 394 deals with what the tribunal may do on completing a review. Of course, it is okay to do a review, but what will be the actions or the consequences of a review? If a review is done and nothing happens, or the power is not there to make something happen, having a review is pointless and just window-dressing. This is why I move —

Page 283, lines 5 to 7 — To delete the lines and substitute —

(3) The Tribunal may make an order or give a direction under subsection (1) in relation to an involuntary patient's treatment, support or discharge plan, and may make —

**Ms A.R. MITCHELL**: The treatment support and discharge plans are made with the involvement of the patient's close family member, the carer or the nominated person amongst other people, which we have agreed is important and has been the whole basis of this bill. It is considered to be inappropriate for the tribunal, which has not had the benefit of working closely with the patient in their recovery, to make binding recommendations. The treatment can be changed by the process of obtaining an independent further opinion and through the powers of the Chief Psychiatrist. We will not support the amendment.

**Dr A.D. BUTI**: It is interesting that the parliamentary secretary talks about management plans of the patient when, very early on in the bill, we talked about the prominence that they should receive, and they were not given the prominence that we asked in our earlier amendments that they be given. However, let us move on to where we are at the moment. What are we looking at here? Once again, we are trying to ensure that the patient receives the best possible treatment. We are looking at involuntary treatment orders. Very early on we dealt with clause 8(2) of the bill, which deals with an advance health directive. It states in part —

For the purposes of ascertaining those wishes, the person or body must have regard to the following —

(a) any treatment decision in an advance health directive made by the person that is relevant to the matter;

That is fine, but it was not given the prominence that we suggested it should be given. If the tribunal does a review, it should be able to make an order that it believes benefits the patient. This is an involuntary treatment order, which means we are looking at the more severe end of the scale. The tribunal should have the ability to do that because if it is to have teeth in the review process, it should have the ability to make an order or give a direction under subclause (1) with regard to the involuntary patient's treatment, support or discharge plan, and then it can do whatever after that, as stated in the rest of the clause.

**The DEPUTY SPEAKER**: Member for Collie–Preston and member for Murray–Wellington, that is a very long conversation you have had there. I suggest you go outside to complete it; go and have a cup of coffee or something. You are distracting.

**Ms A.R. MITCHELL**: The main purpose of the review is to determine whether the person should remain an involuntary patient. The Mental Health Tribunal has binding powers in this area to declare that the patient remains an involuntary patient. Given the arguments we made before about the involvement of a patient's family members, carers and nominated persons, we believe that we do not need to support the amendment.

*Division*

Amendment put and a division taken, the Deputy Speaker (Ms W.M. Duncan) casting her vote with the noes, with the following result —

Ayes (15)

| | | | |
|---|---|---|---|
| Ms L.L. Baker | Mr F.M. Logan | Ms M.M. Quirk | Mr P.B. Watson |
| Dr A.D. Buti | Mr M.P. Murray | Mrs M.H. Roberts | Mr B.S. Wyatt |
| Mr R.H. Cook | Mr P. Papalia | Ms R. Saffioti | Mr D.A. Templeman *(Teller)* |
| Mr D.J. Kelly | Mr J.R. Quigley | Mr C.J. Tallentire | |

Noes (30)

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

Pairs

| | |
|---|---|
| Ms J.M. Freeman | Dr G.G. Jacobs |
| Mr P.C. Tinley | Mr T.R. Buswell |
| Mr M. McGowan | Dr K.D. Hames |
| Ms J. Farrer | Mrs L.M. Harvey |
| Mr W.J. Johnston | Mr B.J. Grylls |
| Ms S.F. McGurk | Mr C.J. Barnett |

**Amendment thus negatived.**

**Clause put and passed.**

**Clauses 395 and 396 put and passed.**

**Clause 397: Declaration about validity of treatment order —**

**Dr A.D. BUTI**: I understand that this clause is about the treatment order, but we have concerns about the ability of this provision to deal with only the narrow scope of the treatment order and not the issues of a referral and a transport order. The parliamentary secretary may think that it is slightly weird that we are talking about the transport order in regards to the treatment order, but I suppose it depends what is meant by "treatment". A treatment order often provides a restriction on the liberties of the patient. As we know, a silly part of this bill is that there could be a referral based on a person's physical condition rather than their mental condition. If I remember rightly, clause 28 provided for that. Therefore, referrals can result in substantial restrictions on the freedoms of the patient. I know that there is a time limit, but the treatment order also results in restrictions on the patient. Our amendment, which I will move shortly, considers the treatment order as a more progressive issue in that it includes the transport order and the referral order, because they all deal with the treatment or possible treatment of the patient. That is why we believe that the Mental Health Tribunal should be required to review the validity of all referrals and orders in the sequence that lead to the current order under review. Therefore, it is silly that only the treatment order itself can be reviewed and that the referral and the transport order that will be part of the sequence or the progression that leads to the final treatment order cannot be reviewed. To that point, I wish to move an amendment in my name that is in the notice paper. I move —

> Page 284, line 6 — To insert after "order" —
>
> , referral or transport order

**Ms A.R. MITCHELL**: I understand what the member may be concerned about but clause 400 makes clear that a treatment order may be declared invalid on the basis of a failure to comply with requirements in the earlier stages of a person becoming an involuntary patient, including the making of referrals and other orders when the failure prejudices the patient's rights or interests. We do not support the amendment.

**Dr A.D. Buti**: Yes, it refers to the referral but it does not refer to "transport order".

**Ms A.R. MITCHELL**: It says "any referral or order".

**Dr A.D. BUTI**: The parliamentary secretary may say that clause 400(a) provides that —

> there has been a failure to comply with the requirements of this Act in relation to —
>
> (i) the making of the treatment order; or
>
> (ii) the conduct of any assessment or examination, or the making of any referral or order, that led to the making of the treatment order;

The parliamentary secretary may make that connection but it does not state explicitly that that connection will be made or must be made. Clause 400 "may" allow the transport order to be reviewed but it is not explicit in the way that the opposition's amendment prescribes. On a few occasions this afternoon we have been trying to make the wording in clauses clearer for everyone to understand and to provide better protection for patients, and the minister has referred me to other clauses that may provide protection or address what some of my amendments seek to do, but they do not make explicit what my amendments are seeking to do. I believe it is very important that there be an express provision to make quite clear that under clause 397 the tribunal will be able to look into the issue of a referral and a transport order.

**Ms A.R. MITCHELL**: I take the member back to members' second reading contributions in which many of them commented on the size of this bill. We all acknowledge that it is extremely large. We acknowledge that the member believes there should be more detail throughout it and we have tried to produce a bill that covers all aspects. Yes, I have been referring the member to other clauses so that I am not being too repetitious throughout the debate. What the tribunal considers will vary considerably in any application for a review and we have to provide that flexibility. In some case there may not even be a transport order. If those words are included in the clause, a transport order will need to be reviewed. We do not believe the member's amendment is necessary.

**Dr A.D. BUTI**: I do not think the size of the bill is a valid argument for not agreeing to our amendment. Although this bill is large, it pales into insignificance compared with the commonwealth Taxation Administration Act or the Corporations Act.

What will the tribunal be there for? I imagine the Mental Health Tribunal will be there to review and make decisions about things that have happened to the patient. A treatment order contains many parts but on plain reading of clauses 397 and 400, they do not provide the mandatory requirement for the tribunal to review referrals, more particularly transport orders, that our amendment seeks to require. The parliamentary secretary talked about the size of the bill, but we are seeking to add four words. I do not think the four words "referral or transport order" will increase the size, the complexity or the amount of repetition in this bill. It is a very important matter and we believe it is important that the tribunal has express jurisdiction over the aspects we are seeking to insert through my amendment.

*Division*

Amendment put and a division taken, the Deputy Speaker (Ms W.M. Duncan) casting her vote with the noes, with the following result —

Ayes (14)

| | | | |
|---|---|---|---|
| Ms L.L. Baker | Mr D.J. Kelly | Mr J.R. Quigley | Mr B.S. Wyatt |
| Dr A.D. Buti | Mr F.M. Logan | Ms M.M. Quirk | Mr D.A. Templeman *(Teller)* |
| Mr R.H. Cook | Mr M.P. Murray | Mr C.J. Tallentire | |
| Mr W.J. Johnston | Mr P. Papalia | Mr P.B. Watson | |

Noes (30)

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

Pairs

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|---|---|
| Ms J. Farrer | Mrs L.M. Harvey |
| Mr P.C. Tinley | Dr K.D. Hames |
| Ms J.M. Freeman | Mr T.R. Buswell |
| Ms S.F. McGurk | Dr G.G. Jacobs |
| Mrs M.H. Roberts | Mr B.J. Grylls |
| Mr M. McGowan | Mr C.J. Barnett |

**Amendment thus negatived.**

**Dr A.D. BUTI**: I will not move the amendment to clause 397 listed on the notice paper.

**Clause put and passed.**

**Clause 398: Consequences of declaring treatment order invalid —**

**Dr A.D. BUTI**: I will not move the amendment to clause 398 listed on the notice paper.

**Clause put and passed.**

Debate adjourned, pursuant to standing orders.