MENTAL HEALTH BILL 2013

Committee

Resumed from 16 September. The Chair of Committees (Hon Adele Farina) in the chair; Hon Helen Morton (Minister for Mental Health) in charge of the bill.

Clause 93: Involuntary inpatient to be advised of expiry —

Progress was reported after the clause had been partly considered.

Hon STEPHEN DAWSON: This clause applies if an inpatient order expires. Under this clause a treating psychiatrist must advise an involuntary patient in writing of the expiry of the inpatient treatment order. Is there a time frame during which the written notification must be provided? There is certainly nothing in the clause that states that it will be done as a matter of priority. Is it simply that the treating psychiatrist must advise an involuntary patient in writing of the expiry and its consequences? Is there a time frame, and will the guidelines and/or the regulations mention or acknowledge that the written advice should be provided without haste?

Hon HELEN MORTON: The Mental Health Bill creates a two-stage process in relation to the expiry of an inpatient treatment order. Firstly, clause 95 creates immediate requirements around persons released from detention, and they involve advising the patient in writing that he or she can no longer be detained and why, and permitting the person to leave. The written notice must be provided as soon as practicable—see clause 95; in particular, clause 95(2). In practice these immediate actions would normally be carried out by a senior nurse. Secondly, clause 93 obliges the patient's psychiatrist to provide follow-up advice regarding the expiry of the order and the consequences of the expiry. This is also an opportunity for the psychiatrist to provide comments on the person's progress and the future treatment and care. Clause 93 does not set out a time frame for providing this follow-up advice; however, it is an established principle of statutory interpretation that when no time frame is stipulated, actions must be performed within a reasonable time. In addition to the requirements relating to notification of the patient, there is also a requirement that at least one close family member, carer or other personal support person be notified of the expiry of the order. The notification must be provided as soon as practicable, and that is contained in clause 139(1). To summarise: when an inpatient order expires, the patient must be notified of their right to leave and associated reasons as soon as practicable. The person's psychiatrist must then follow up with the patient within a reasonable time.

Clause put and passed.

Clause 94 put and passed.

Clause 95: Person must be allowed to leave —

Hon SALLY TALBOT: The minister's answer indicates that we have to read clauses 93 and 95 together. Why is there no provision that once a person becomes subject to clause 95 and therefore must be allowed to leave, that, in and of itself, is not a notifiable event under part 9?

Hon HELEN MORTON: I draw the member's attention to the fact that division 4 includes clauses 94 and 95, which refer to release from "hospital or other place", and that those clauses have to be read in conjunction with one another and that the requirement under part 9 is that it is a notifiable event when patients are released from involuntary detention.

Hon SALLY TALBOT: I know that the minister will be aware of the cases that I am thinking of. I am concerned that there is confusion or a line that is not always clearly definable between the status of a voluntary patient and the status of an involuntary patient. We know of cases under the current act in which somebody's status changes and they suddenly find themselves to be a voluntary patient and not an involuntary patient and, therefore, they do not have a right to appear before the Mental Health Review Board. Is that not the case?

Hon HELEN MORTON: When a person's status is moved from involuntary to voluntary patient, there is no confusion; that is absolutely clear. The bill makes it very clear that the person must be advised of their right to leave as soon as practicable. That is the process by which a person's status moves from involuntary to voluntary. They are informed that they can leave hospital if they wish to and they are now not required to be at the hospital if they do not want to continue with their treatment. Often, however, a person's treatment could be ongoing as a voluntary patient, but the status of "involuntary care" has now been moved to "voluntary" and the patient is not required to be there if they wish to leave.

Hon SALLY TALBOT: I did not explain myself very well. When I said there was confusion between the two statuses, I did not mean there was official confusion, because clearly a person is always either a voluntary or an involuntary patient. Perhaps I can phrase the question in a different way: is it a notifiable event when a voluntary patient is discharged?

Hon HELEN MORTON: No; these are people who have given consent to their treatment; they are not detained. They can be released from hospital or they can leave hospital of their own choosing, so there is no requirement for those people to be notified, and it is not a notifiable event under schedule 2.

Hon SALLY TALBOT: Is it a requirement that the family of a voluntary patient is advised when they are discharged?

Hon HELEN MORTON: It is not a requirement; however, on many occasions, and by far on most occasions, good practice determines that families are notified when a person is leaving hospital. Frequently that is for the purpose of ongoing care and outpatient appointments as the family's involvement supports that process.

Hon SALLY TALBOT: Of course, the Stokes report showed us that that is indeed the case in an ideal world, but, unfortunately, Western Australia does not come anywhere close to being that ideal world, hence my questions here. On the basis of the minister's two answers, I can now phrase the question in a clearer way. A person becomes a voluntary patient the moment the mandatory order that makes them an involuntary patient expires. For example, at midday, a person can be an involuntary patient and when they are discharged there is a statutory requirement for the family to be informed and it is a notifiable event; but at five past 12, if they become a voluntary patient, neither of those statutory requirements applies to that person.

Hon HELEN MORTON: The member's comments are correct. If a person is released as an involuntary patient, it is notifiable. If a person is released as a voluntary patient, it is not a notifiable event.

Hon SALLY TALBOT: I agree. We are in furious agreement here, but is that a satisfactory situation when in a matter of minutes a patient's status can change as far as those statutory provisions apply? Why can we not have a provision whereby if somebody has been an involuntary patient and their order expires, they are therefore informed, as the minister said in her previous comments on clause 93, after a reasonable amount of time—in other words, as soon as possible? Would it not be sensible to have that statutory provision still apply to that person? Why would we want to drop the statutory safeguard that is in place at midday and all of a sudden at five past 12 is no longer deemed to be necessary to the welfare of the patient? I am not explaining it very well, but I think the minister understands the point I am making; it is a point of commonsense. I am sure the minister knows there have been cases in which a patient's status changes and because of that change they lose rights that they would have had as an involuntary patient.

Hon HELEN MORTON: A notification requirement applies at the time of release from detention. Is the member talking about a person who is an involuntary patient, then at midday becomes a voluntary patient?

Hon Sally Talbot: Yes.

Hon HELEN MORTON: At midday, when they move from their involuntary status to voluntary status, that is a notifiable event, so the notification requirements around that will have to be undertaken. If the person is a voluntary patient at the time they are discharged from hospital, the bill requires that people be involved in that discharge plan—a nominated person, a family member et cetera. Subsequently, when that person is discharged, it has already been determined that there is a notifiable event from involuntary to voluntary status, and there is no requirement then to go further with that notifiable event at the time of discharge.

Sitting suspended from 6.00 to 7.30 pm

Hon SALLY TALBOT: I was in the process of getting some clarification about the change of status of a patient. The point I am making is fairly clear. Provisions might apply to a person when they are an involuntary patient. That is put in place specifically to protect the interests of that person and to include the family in all sorts of decision-making. Suddenly, their status changes to voluntary patient and they are in a completely different category. The member pointed out that because of the provisions of clause 93 there would be a point when the order changes—that is, when the carer or the family member, or whoever the designated person is, is notified about the change. Before we rose for the dinner break I was about to make the point that it does not require too much of an exercise of the imagination to imagine a situation. Statutory notification of the event takes place when the status of the patient changes. I am picking random times. Let us stick with midday. Would it not be reasonable to provide for a period of time to avoid a situation—which I do not think is that far-fetched—in which a carer is advised at midday that the person they care for has just been made a voluntary patient? In other words, the involuntary order has expired. Provision is then made to come into the hospital to collect the person or to sit with the person to plan whatever they will do next. They arrive at the hospital or the establishment where the person has been held as an involuntary patient only to be told that the patient has discharged themselves or been discharged, which of course is a perfectly allowable thing under the bill. Given that the person whose status changes will presumably still be vulnerable, at least to a degree and perhaps more than somebody walking past in the street outside, should we not make some provision to ensure there is no risk of discharge before it has been properly planned?

Hon HELEN MORTON: I reiterate that when a person is made a voluntary patient from an involuntary status, it is a notifiable event. There is, therefore, a requirement for people to be notified—other than the patient, I am talking about; so the person will now be made aware of that situation.

I also want to say that when a person becomes a voluntary patient, they are in the same situation as you or I or anybody else in determining that they may or may not stay at the hospital and may or may not consent to any further treatment. The patient, under those circumstances, has a right to determine their discharge arrangements. I would not want to take that away. We are seriously looking to encourage people to take responsibility for their circumstances, their outcomes and their decisions on treatment et cetera.

The member made reference to specific cases in which a patient was not made aware of a change in their patient status. That is what happens under the current act, because there is no requirement to notify anybody. Obviously, these issues do arise under the current act. One of the many deficiencies of that act as it is currently is that it does not require staff to notify the patient when their status changes. That is being remedied in the bill through the new requirements contained in clause 95, which relate to notification of the patient, and clause 90(5), which requires notification of at least one carer, close family member or other personal support person. Part 9 of the bill was included following consultation on the 2011 draft bill. That was the feedback we got that caused us to insert that in the way that it is. The intention is to ensure that at least one support person knows where their loved one or family member is at any given time. I think the member queried the position of an involuntary inpatient who becomes a voluntary patient and is consequently able to leave the hospital. As I said, clause 90 covers that, so that that support person must be notified. I think I have answered the member's questions.

Hon SALLY TALBOT: I just want to ask the minister about the guidelines or the regulations, or whatever the word was that the minister was using.

Hon Helen Morton: The standards.

Hon SALLY TALBOT: Is the minister anticipating that the standards or regulations will give some specific guidance about this period of transition? I know that technically it is not a period of transition, but my question is about how a patient will be managed through that change of status.

Hon HELEN MORTON: One of the hallmark changes in this bill compared with what is in the current act is a requirement for every patient to have a treatment, support and discharge plan, and that families are involved in the determination and making of it and ensuring it is followed through. A family member's involvement will ensure that if the patient and family member want to be contacted at the time the discharge takes place, it is in the plan and they will be required to follow through on that.

Clause put and passed.

Clauses 96 to 104 put and passed.

Clause 105: Granting leave —

Hon SALLY TALBOT: I have just a very quick question, which is a continuation of that same line of questioning. I wonder whether the minister could comment about whether there is a need under clause 105, which is about granting leave, to have some sort of provision for notifying families or carers when a patient is granted leave.

Hon HELEN MORTON: This is covered at clause 105(13).

Hon SALLY TALBOT: That clause states that it is a notifiable event; it does not actually state that the family or the carer has to be told.

Hon HELEN MORTON: That is what a notifiable event is. Also, clause 105(2) outlines that the psychiatrist cannot make the order unless the psychiatrist has consulted with the people who I think the member is referring to.

Clause put and passed.

Clauses 106 to 117 put and passed.

Clause 118: Monthly examination of patient —

Hon SALLY TALBOT: This question is about clause 118, but it goes as far as clause 119 as well, I think. I want clarification about the various references to "supervising psychiatrist", "another medical practitioner", "mental health practitioner" and "medical practitioner". I just want to be clear: when a patient is reviewed, if they are subject to an involuntary order or a community treatment order, does it have to be done by a psychiatrist?

Hon HELEN MORTON: I am just getting absolute clarification on this. This is about the monthly examination of a patient. The requirement is that for the first two months, the review can be undertaken by a medical practitioner or a mental health practitioner, and they have to provide a report to the psychiatrist. But they cannot go any longer than that without the psychiatrist's review. The third-month review must be by the psychiatrist. Also, a monthly examination by a practitioner other than a psychiatrist cannot lead directly to the person's detention as an involuntary patient. The person would first need to be examined by a psychiatrist. The review process is not about whether the person needs to be made involuntary; it is about whether the person is maintaining their medication, is managing okay, and things are moving ahead okay et cetera. But that report has to be made to the psychiatrist, and the third-month review must be done by a psychiatrist.

Hon SALLY TALBOT: Is this the provision that picks up on the point made by Professor Stokes about the general medical health of the patient, not just the patient's psychiatric health? Is this where, for example, dental care would be monitored?

Hon HELEN MORTON: As we have indicated, the Chief Psychiatrist will publish a standard on assessing and monitoring the person's physical health in and throughout these processes, so it is not just this particular review; other aspects relate to that. However, although this monthly examination of the patient will encapsulate that, it is primarily around undertaking the review of the person's mental health and psychiatric treatment requirements.

Hon SALLY TALBOT: I refer the minister back to the new definition that we put in clause 4 about the health professional. Can any of these monthly reviews be done by the health professional?

Hon HELEN MORTON: No. It is the mental health practitioner, and that is a definition within the bill.

Hon Sally Talbot: So none of these monthly reviews can be done by the health professional?

Hon HELEN MORTON: No; it has to be a mental health practitioner.

Clause put and passed.

Clauses 119 to 125 put and passed.

Clause 126: When involuntary community patient will be in breach —

Hon HELEN MORTON: I move —

Page 95, lines 22 to 28 — To delete the lines and insert —

(c) the supervising psychiatrist reasonably believes that, despite the steps that have been taken, the non-compliance is continuing and that, if the non-compliance continues, there is —

(i) a significant risk to the health or safety of the involuntary community patient or to the safety of another person; or

(ii) a significant risk of serious harm to the involuntary community patient or to another person; or

(iii) a significant risk of the involuntary community patient suffering serious physical or mental deterioration.

Clause 126 sets out the circumstances in which a patient on a community treatment order will be in breach of their CTO. Under the current drafting, the CTO breach process is available only if there is a risk of serious deterioration. It is not available in response to the other types of risks specified in clause 25, "Criteria for involuntary treatment order". The CTO breach process is a less restrictive option than the making of an inpatient treatment order. As such, it should be available as an option even if the person technically meets the inpatient criteria. The proposed amendment achieves that outcome.

Hon STEPHEN DAWSON: Again, we have an amendment that seeks to insert the words "serious harm" into the bill. I think we had a fairly lengthy discussion about this issue during debate on clause 25. As members would be aware, members on this side of the chamber have expressed concern about the possible definition of "serious harm" and how broad that definition might be. I will not spend much time on this issue but I want to ensure that our concern is raised again. I do not believe the minister touched on the issue of "serious harm" in the comments she made a few minutes ago and we should not skirt over it. There is concern on this side and in the sector that this definition could cause concern for people in the community. We do not believe it should be so broad, and we will be voting against this amendment.

Hon HELEN MORTON: Under the current drafting, the CTO breach process is available only if there is a risk of serious deterioration. It is not available in response to the other types of risk specified in clause 25—that is, the criteria for an involuntary treatment order. Even though the will of the house, rather than the opposition, has

accepted that the criteria that we have identified in clause 25 applies, the criteria needs to apply in this clause as well.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 127 and 128 put and passed.

Clause 129: Making transport order —

Hon HELEN MORTON: I move —

Page 98, after line 4 — To insert —

(5) The making of a transport order under subsection (2) is an event to which Part 9 applies and the practitioner who makes the order is the person responsible under that Part for notification of that event.

I think this amendment will be supported because under the current drafting, when an involuntary community patient is made subject to a transport order, there is no requirement that a support person be notified. However, this amendment remedies that and makes it clear that that will be a requirement.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 130 to 132 put and passed.

Clause 133: Making transport order —

Hon HELEN MORTON: I move —

Page 102, lines 3 and 4 — To delete —

because of the involuntary community patient's mental or physical condition,

Hon SALLY TALBOT: Again we have come to a point in the Mental Health Bill 2013 where I am uneasy about an apparent inconsistency, so I invite the minister to talk about why we are here deleting references to a patient's mental and physical condition, when the amendment the minister moved before the last amendment, which we welcomed, inserted, by way of a substantial amendment, a reference to a patient's mental and physical condition. We bear in mind, of course, that it is the physical condition of the patient that concerns us when that comes under a provision in a mental health statute.

Hon HELEN MORTON: I am not sure if the member is seeing this as the same amendment that we have been making collectively throughout the bills, where the words "mental and physical condition" become superfluous because we have already covered off on that earlier in that process. A person who is referred and requires a transport order already meets those requirements.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 134 to 138 put and passed.

Clause 139: Right of any carer, close family member or other personal support person to be notified —

Hon HELEN MORTON: The next 15 amendments on the notice paper all refer to this same issue, and so if people are comfortable with that, I will not get up and explain the reason for it every single time. However, the proposed amendments to clauses 139 to 144 address a drafting issue. The amendments achieve consistency of language across part 9 by replacing reference to "nominated person, carer or close family member" with the slightly broader phrase, "carer, close family member or other personal support person".

The DEPUTY CHAIR (Hon Liz Behjat): Is the minister seeking leave to move these amendments en bloc or does the minister want to deal with them individually?

Hon HELEN MORTON: If that is possible, it would make the process go rather quickly and smoothly up to the end of those next 15 amendments.

The DEPUTY CHAIR: If the Committee of the Whole agrees, I am advised that the amendments to the following clauses can be moved en bloc and then the committee can ratify each amended clause, if they are agreed to, clause by clause. If the house is happy to deal with the amendments in that way, that is how we will deal with them.

Hon SALLY TALBOT: Hon Stephen Dawson has indicated that that is okay.

I have a question before we proceed. The minister is calling this a drafting error, but I believe the amendments remove all references to "nominated person". Can the minister confirm whether that is right? If I am wrong, then I might change what I am going to say.

Hon HELEN MORTON: A nominated person is still included, because they are picked up in the reference to a "personal support person". I can give Hon Sally Talbot more detailed information about that, given that we are going to go through the whole lot in one hit.

Hon Sally Talbot: If you could.

Hon HELEN MORTON: Clause 7 has the definition of a "personal support person". I reiterate that, because I want Hon Sally Talbot to be comfortable with that.

Hon Sally Talbot: I can do two things at once.

Hon HELEN MORTON: Clause 7's definition of a personal support person includes the nominated person. Part 9 entitles carers, close family members and other personal support persons to be notified of certain events. Clause 142 creates an exception where notification of a particular person is not in the patient's best interests. This exception is subject to strong checks and balances. The decision must be reported to the Chief Mental Health Advocate and the excluded person may appeal the decision to the Mental Health Tribunal. The policy intent is that the best interests exception should be able to be invoked for any person who would otherwise be entitled to receive a notification under part 9. It was recently brought to my attention that the current drafting does not quite achieve this result. This is due to differences in the terminology used in clause 139(1), which creates the entitlement, and the clauses that deal with the best interests exception, the proposed amendments address this issue by achieving consistency of language across part 9.

To illustrate the effect of this change with an example, the current drafting creates an anomaly whereby the best interests exception may be invoked for a parent who provides ongoing care and assistance to a child but not in relation to a parent who is estranged from their child. I anticipate that use of the best interests exception will be rare, especially in relation to a parent. However, the unfortunate reality is that child abuse by parents does occur. It would be a perverse outcome if services were required to automatically contact abusive parents especially where the child's mental health condition is understood to be linked to that parental abuse. I would like to again stress that the exercise of the best interests exception will be subject to robust checks and balances. The Chief Mental Health Advocate must be notified and the decision may be challenged before the independent Mental Health Tribunal.

Hon SALLY TALBOT: How many of those robust checks and balances will be contained in the bill in statutory form and how many are being deferred to the regulations, standards or guidelines?

Hon HELEN MORTON: I am advised that they are all in the bill. Clause 142(3)(b) is an example of where they are embedded in the bill.

Hon SALLY TALBOT: The minister has just expanded the definition of a drafting error beyond anything that I have been aware of up to this stage, but we will let that ride. Can I confirm that a personal support person would include a lawyer?

Hon HELEN MORTON: The definition of "personal support person" refers to clause 7 and includes a carer, a close family member, a nominated person, an enduring guardian or guardian of an adult or a parent guardian of a child.

Hon SALLY TALBOT: It does not include a lawyer. Yet the words the minister is proposing to delete in this clause would presumably have included a lawyer under "nominated person"?

Hon HELEN MORTON: I am not certain the member is asking whether a lawyer is one of the nominated people. A person can choose their lawyer to be a nominated person, but it is not automatic that a lawyer is a nominated person.

Hon SALLY TALBOT: I understand that. Are we not deleting the reference to "nominated person"?

Hon HELEN MORTON: We are, but it is picked up under the definition of a personal support person. Again, a nominated person is one of the personal support persons specified in clause 7. Wherever "nominated person" is mentioned, that is picked up in the definition of the personal support person. It is not that we have reduced the number of support people a person can choose from; it has clarified that it can be a carer, a close family member, a nominated person—so that is included—an enduring guardian, or guardian of an adult or a parent guardian of a child.

Hon SALLY TALBOT: I think I am almost there. I will check with the minister that under clause 7(2)(b)(iii) the nominated person could be a lawyer, if the patient chooses to make the lawyer the appointed person.

Hon HELEN MORTON: It can be anybody in the world as long as they are over the age of 18. The proposed amendment is not preventing the support person from being a lawyer.

Hon SALLY TALBOT: That is the definition of personal support person in clause 7.

The DEPUTY CHAIR (Hon Liz Behjat): The minister is now seeking leave under standing order 132(b) to move amendments en bloc to clauses 139 to 144, excluding clause 141 because there is no amendment proposed there.

Hon HELEN MORTON — by leave: I move —

Clause 139

Page 104, lines 21 and 22 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Clause 140

Page 105, line 4 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 105, line 5 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Clause 142

Page 106, line 2 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 106, line 9 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 106, line 11 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 106, line 15 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 106, line 18 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Clause 143

Page 106, line 29 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 106, lines 30 and 31 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 106, lines 33 and 34 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 107, line 3 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Clause 144

Page 107, lines 17 and 18 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 107, line 23 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 107, line 26 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Page 107, lines 28 and 29 — To delete "nominated person, carer or close family member" and insert —
carer, close family member or other personal support person

Amendments put and passed.

Clauses 139 and 140, as amended, put and passed.

Clause 141 put and passed.

Clauses 142 to 144, as amended, put and passed.

Clause 145: Making, revocation or expiry of involuntary treatment order —

Hon STEPHEN DAWSON: We are making good progress, Hon Kate Doust. People were concerned. We will be out of here by Christmas! I move —

Page 108, after line 31 — To insert —

(aa) the Chief Psychiatrist;

Division 3 relates to the making, revocation or expiry of involuntary treatment orders. The opposition supports the Chief Mental Health Advocate and the Mental Health Tribunal being notified of the making, revocation or expiry of an involuntary treatment order. We support the Chief Psychiatrist being kept in the loop on this matter, and we simply say that it is good governance.

Hon HELEN MORTON: We do not support the amendment for the following reasons. The suggestion that involuntary treatment orders be automatically forwarded to the Chief Psychiatrist has been considered in the past—most recently in debate in the other place—and I am not persuaded that the change is justified. The reason that the Chief Mental Health Advocate and the Mental Health Tribunal are included in clause 145(4) is that they are required to take specific action in respect of every involuntary patient. In the case of the chief advocate, this means ensuring that every involuntary patient is visited or otherwise contacted within seven days. In the case of the tribunal, there is an obligation to schedule mandatory reviews in line with the period stipulated in part 21. The Chief Psychiatrist has no equivalent responsibility. Although it is true that some of the powers of the Chief Psychiatrist are directed specifically to involuntary patients, there is not one function that the Chief Psychiatrist must automatically perform in respect of each and every involuntary patient. It is therefore not necessary for the Chief Psychiatrist to receive each and every order. Of course, the Chief Psychiatrist is empowered to access these forms directly from services as required; for example, if a patient or a mental health advocate alerts the Chief Psychiatrist to a concern relating to a particular patient, the Chief Psychiatrist may obtain all relevant information about the patient. Similarly, if the Chief Psychiatrist wishes to undertake an audit of involuntary treatment orders, the necessary information can be obtained on request. Advice from the current Chief Psychiatrist is that automatic provision of involuntary information orders would create additional administrative work without assisting in the performance of the office's functions and powers.

Hon STEPHEN DAWSON: I do not propose that we spend too long on this issue. Obviously, there is a fundamental disagreement between this side and the other side. We support the Chief Psychiatrist and the Chief Mental Health Advocate being told various things under this legislation, and obviously the government does not, which is a shame. Can the minister advise why the patient's guardian or choice of treating practitioner or lawyer was not included in the list in clause 145(4)?

Hon HELEN MORTON: I comment that in the earlier part of Hon Stephen Dawson's response he did not at any time indicate why he believes that the Chief Psychiatrist should be notified, given that the Chief Psychiatrist does not have a function in relation to each and every involuntary patient. Although I heard the comment that he believes that the Chief Psychiatrist should be notified of all information, nothing made me think about why that should be the case. Does the member have some additional information on why he thinks every single involuntary patient should be notifiable to the Chief Psychiatrist even though the Chief Psychiatrist is not going to do anything with that information and undertake any function as a result of having received that information? At least one personal support person must be notified of part 9 events. Personal support persons are close family members, carers, nominated persons, a parent or guardian of a child or guardian or enduring guardian of an adult. The administrator may fall within one or more of these categories, for example, if they are a guardian and a close family member. The administrator's role is obviously very different from that of a guardian and they should not be privileged above personal support persons. There is nothing preventing the personal support person or the person who has been notified under part 9 from informing the administrator or any relevant person of notifiable events.

Similarly, there is nothing preventing the patient, a support person or a mental health advocate from contacting the patient's current treating practitioner. I have already moved a number of amendments aimed at ensuring detained persons have the means and opportunity to contact their treating practitioner at all reasonable times, and inserting this requirement would create additional work for services without a commensurate benefit to patients. There is also nothing preventing the patient, a support person or a mental health advocate from contacting the patient's lawyer.

Hon STEPHEN DAWSON: I think the minister was trying to bait me that time. However, I am not taking the bait. We could stay here all night and debate this point.

The DEPUTY CHAIR (Hon Liz Behjat): I am not sure that we could stay all night!

Hon STEPHEN DAWSON: We could certainly stay for a couple more hours and debate this point. However, I think the minister made up her mind on this point before I said anything this evening, so anything that I say on the issue will not change her mind. The fact remains that we support the Chief Psychiatrist being kept in the loop because we simply believe it is good governance. I take the minister's point; we are going to agree to disagree.

Hon SALLY TALBOT: I seek your guidance, Madam Deputy Chair. I have a couple of other questions about the clause and not so much about the amendment; should I do that now?

The DEPUTY CHAIR: That is appropriate; you can do that now.

Hon SALLY TALBOT: I heard the minister refer us to guardians et cetera. Was the minister referring to clause 145(1)(b)(i) when she was talking about guardians?

Hon HELEN MORTON: As I indicated previously, they are included in the definition of a "personal support person".

Hon Sally Talbot: So that's clause 4?

Hon HELEN MORTON: That is where the definition is.

Hon SALLY TALBOT: Given that we were unsure whether the minister would support the amendment moved by Hon Stephen Dawson, my question was about whether other people needed to be notified—for example, guardians or lawyers. If we are referring back to the definition under clause 4 of "personal support person", it does not look to me as though there is any statutory obligation to inform them; it looks as though if they have been informed, they come under the provisions of clause 145(1), but there is no obligation to inform them. Would the minister like me to elaborate on that?

Hon Helen Morton: No. I know that sometimes it might look like I take a little bit of time, but I want to make certain you get the information you're looking for.

Hon SALLY TALBOT: That is okay.

Hon HELEN MORTON: I refer Hon Sally Talbot to clause 139, which refers to the personal support person and the nominated person et cetera, which is included in the support person amendment that we made. The guardians are entitled to notifications because they are personal support persons.

Hon SALLY TALBOT: If the minister can just help me here, where is the reference to that in clause 145?

Hon HELEN MORTON: Clause 145 ensures that bodies such as the Mental Health Tribunal and the Mental Health Advocate are informed. It is the same approach to making sure that the personal support persons are informed as is taken at clause 139.

Amendment put and negatived.

Clause put and passed.

Clauses 146 and 147 put and passed.

Clause 148: Making transport order —

Hon STEPHEN DAWSON: I move —

Page 111, after line 29 — To insert —

(aa) give a copy to the Chief Psychiatrist and the Chief Mental Health Advocate; and

This is about transport orders in part 10. There is no doubt transport orders are significant events. Obviously, they involve moving people from one place to another; that could be to an authorised hospital or to a general hospital in certain cases. In many cases, particularly for involuntary patients who are being held against their will, this can be the start, or very near the start, of a person's detention. The minister is on the public record as saying that under this bill, patients' rights and freedoms are important and the bill should impose the least infringement on those rights and freedoms. The use of the powers of involuntary transportation impinges on the freedoms and rights of patients. For this reason we believe the Chief Psychiatrist and indeed the Chief Mental Health Advocate should be given a copy of the transportation order. This amendment mandates that a copy of the transport order be given to the Chief Psychiatrist and the Chief Mental Health Advocate. It is not about burdening the system; it is about protecting the patient's rights.

Hon HELEN MORTON: The government will not support this amendment. The Chief Psychiatrist and the Chief Mental Health Advocate are already empowered to access relevant documents, including transport orders,

subject to a patient's ability to object to that. The Chief Mental Health Advocate's powers are in clause 359 and the Chief Psychiatrist's powers are in clause 519. If we require every transport order to be sent to the Chief Mental Health Advocate and the Chief Psychiatrist, it would mean more time is spent circulating and managing paperwork, electronically or otherwise, and less time performing functions that assist patients and their loved ones. We also need to be mindful that transport orders are often made in crisis situations by practitioners working in the community, such as GPs, who may not have the administrative support needed to comply with the extra reporting requirements. As noted in clause 145, the Chief Psychiatrist is not expected or required to take specific action in relation to each and every patient. If for whatever reason the Chief Psychiatrist needs to obtain a transport order, this can be achieved using the power set out in part 23. Similarly, advocates do not automatically become involved every time a person is transported; rather, the bill includes measures that will assist those who require advocacy support to obtain it.

The other point I will make is that the transport order is to enable somebody to get from A to B. If they are being transported to a place where they become an involuntary patient, the chief advocate will be automatically nominated at that point.

Hon SALLY TALBOT: That final point might be the key point. Can the minister elaborate on that? Let us check that we understand this correctly. Will most of the people subject to a transport order be already subject to those referral orders we were talking about last night?

Hon HELEN MORTON: Transport orders are always made following a referral order. As we have previously discussed under other clauses, it is a requirement that every referred person be provided with information about contacting the chief advocate if they wish while they are in that referral phase. A transport order is to get someone from A to B. As we heard previously, about 5 000 referrals are made each year. About 50 per cent of those people become involuntary patients. The chief advocate will be automatically notified once that order is made. Of those 50 who are not made involuntary, some are discharged and some are voluntary patients who can make contact with whomever.

Hon SALLY TALBOT: I will summarise the minister's comment as I understood it: if this amendment were adopted, it would increase the amount of paperwork and it would take time away from people providing care at the coalface for people with mental illness. Only this morning I spoke with somebody who used to work as a St John Ambulance officer. She was allocated to a category of cases that were not medical emergencies. A lot of cases she dealt with were involuntary patients being transported. She said that it was a very regular occurrence for those patients to be comatose. When we were talking last night about referral orders, the minister said that emergency psychiatric treatment will often involve sedation. I want to support what Hon Stephen Dawson said about the fact that we are dealing with people. Even if the minister were to suggest to us that we limit the effect of this amendment to certain categories of patient, we would at least make sure we include patients who are clearly not able to avail themselves of the statutory possibility of consulting the Chief Mental Health Advocate. If somebody who needs emergency psychiatric treatment is unconscious, they are not exactly in a position to make a decision to contact the Chief Mental Health Advocate. Hon Stephen Dawson's proposed amendment ensures that people in that position at least have that added safety net placed under them. I have not discussed this with Hon Stephen Dawson, but I am sure that if the Minister for Mental Health wanted to counter his amendment with a suggestion that perhaps she would accept it if it was in some way circumscribed, it would at least give us something to work with that would achieve the basic objective, which is to provide more assistance to the most vulnerable people.

Hon HELEN MORTON: Obviously, I support the sentiment of what Hon Sally Talbot is saying, but it is already covered. Clause 244 requires that a referred person be provided with an explanation of their rights as described in the regulations. Clause 245 requires that the explanation also be provided to at least one support person, such as a nominated person. The support person may then contact the advocacy service directly or assist the referred person to do so if in fact they are not able to do so themselves.

Amendment put and negatived.

Clause put and passed.

Clauses 149 to 153 put and passed.

Clause 154: Revocation of transport order if no longer needed —

Hon STEPHEN DAWSON: I move —

Page 115, after line 22 — To insert —

(aa) give a copy to the Chief Mental Health Advocate; and

Clause 154 allows for the revocation of a transport order if no longer needed. Again, we believe that the Chief Mental Health Advocate needs to be kept abreast of all parts of the mental health system and its interaction with patients. Therefore, I have moved this amendment.

The DEPUTY CHAIR (Hon Simon O'Brien): The Minister for Local Government.

Hon HELEN MORTON: Pardon?

The DEPUTY CHAIR: I am sorry; my mind was distracted. The Minister for Mental Health who is representing the Minister for Local Government on other occasions!

Hon HELEN MORTON: That is correct, but not tonight.

The DEPUTY CHAIR: I was getting ahead. Let us start again. The Minister for Mental Health is recognised.

Hon HELEN MORTON: Thanks, Mr Deputy Chair.

Although I understand Hon Stephen Dawson's concerns and feelings about this amendment, given that we have already passed the clause that the member sought to amend so that the Chief Mental Health Advocate would be notified but the amendment was not supported, this should almost drop away. However, I understand that the member is not prepared to accept that. Consequently, I have to say that we do not support this amendment for the same reasons that we did not support the proposed amendment to notify the Chief Mental Health Advocate, let alone being notified when a transport order is no longer needed. This amendment corresponds to the proposed amendment to clause 148 requiring that all transport orders be provided to the Chief Mental Health Advocate. The defeat of the primary amendment makes this corresponding change redundant.

Amendment put and negatived.

Clause put and passed.

Clause 155 put and passed.

The DEPUTY CHAIR: Hon Stephen Dawson is to move new clause 155A standing in his name on the supplementary notice paper.

Hon STEPHEN DAWSON: Mr Deputy Chair, I seek your guidance, but I think that, given the debate we had at clause 28, which sets a maximum period of 144 hours, this amendment falls away.

The DEPUTY CHAIR: If the member does not wish to move it, we will leave it.

Hon STEPHEN DAWSON: Perhaps I could seek your guidance, Deputy Chair. In light of that decision at clause 28, does this amendment fall away?

The DEPUTY CHAIR: I would not disagree with that view, and I am sure the minister would not disagree. It is up to the member if he wishes to move it, however. There is no law that says that a bill that comes out of this place has to make sense.

Hon Adele Farina: It is preferable.

The DEPUTY CHAIR: That is literally the case, but I appreciate the fact that the member is asking the question. However, ultimately, it is members' supplementary notice paper. If the member does not wish to move it, I am sure he has good reason not to.

Hon STEPHEN DAWSON: I will not move it.

The DEPUTY CHAIR: That being the case, we will move on to clause 156, and there is an amendment on the supplementary notice paper standing in the name of Hon Stephen Dawson.

Clause 156: Apprehension by police officer of person suspected of having mental illness —

Hon STEPHEN DAWSON: I move —

> Page 117, after line 24 — To insert —
>
> (aa) must, as soon as practicable after apprehending a person under subsection (1), notify the Chief Mental Health Advocate of such action; and

Clause 156 deals with police powers and people who have not committed a criminal offence but are suspected of having a mental illness. This is another area in which we believe the bill is deficient. We believe there should be a requirement for the Chief Mental Health Advocate to be notified.

Hon HELEN MORTON: The government will not support this amendment. A police officer who apprehends a person under clause 156 has two urgent priorities. The first is ensuring the person's safety and the second is arranging for the person to be assessed by a mental health professional. Additional administrative requirements would divert the officer's attention from those two urgent tasks. Further, it would be premature for a mental

health advocate to be involved before the person has even been assessed by a qualified professional. This assessment could have a number of different outcomes, most of which do not involve the exercise of further powers under the bill or warrant the involvement of an advocate. For example, a person's condition could improve without further intervention, the person could consent to treatment, a substitute decision-maker could consent on the person's behalf or it may be determined that the person did not have a mental illness in the first place. In all these scenarios, the presence of a mental health advocate would offer little or no value—that is if the advocate could be there at all. The assessment process will often be completed before an advocate can make any sort of contribution. In such cases, the advocacy service will have received and managed paperwork that results in no action that benefits the patient. Of course, the bill recognises that the importance of advocacy involvement escalates once a person is referred for examination by a psychiatrist.

Hon STEPHEN DAWSON: We are not asking for the mental health advocate to be there the whole time; we are just asking for the Chief Mental Health Advocate to be notified as soon as practicable after the apprehension under clause 156(1). It is not a case of saying that they have to be there during whatever is going on; it is just them being notified of it, knowing of it and then being able to investigate it afterwards. I do not get the point the minister is making.

Hon HELEN MORTON: Without being too flippant, ditto, because there is no point in the Chief Mental Health Advocate being notified if they cannot do anything and they have no role or involvement if the processes we are talking about are to go forward. If by some chance the person is then referred for assessment, the person will be given information about the Chief Mental Health Advocate and will be given the option, through a nominated person or themselves, to make contact with the Chief Mental Health Advocate. However, up until that point, those processes are usually happening fairly quickly and there is no particular role that the Chief Mental Health Advocate could have. Consequently, if the patient does go on to be referred, the Chief Mental Health Advocate can be notified by the patient or the patient's nominated person.

Hon SALLY TALBOT: I want to speak really strongly in support of this amendment. I think it is very, very important. With this amendment, Hon Stephen Dawson has been able to pick up, with one fairly simple, straightforward measure, all the concerns that underlie clauses such as this in a bill, and I will tell members why. We are dealing with the added complication that the person with a mental illness that is serious enough to warrant at least the possibility, if not the actuality, of a mandatory detention or mandatory treatment order also having found themselves involved in not just a mental health emergency, but a mental health emergency that involves the police. We do not have to go back very far through news bulletins to find occasions when these interventions by police have gone horribly wrong and people have died as a result of miscalculations. I know the minister will say that those are the exceptions and they might be covered by other provisions, but I just want to go back to the point that, with this amendment, Hon Stephen Dawson is ensuring that if anything goes wrong and somebody gets seriously hurt or even dies—as I say, this is thankfully not a regular occurrence, but not an unknown occurrence either—there will at least have been some mechanism whereby the Chief Mental Health Advocate will have had the notification at the time of the incident and will be at least in a position to monitor what is happening.

The police officers in this state I think are a little ahead of their colleagues in the other states. In New South Wales, for instance, it was not until very recently that mental health training was given to police officers. That is not the case in this state. However, I have some statistics from the beginning of this year that suggest that there are an enormous number of incidents in which the police encounter mental illness. In 2012, there were in the region of 1 620 incidents, and in 2013, there were 961. These are provisional figures. For what is called "mental health incidents", in 2012, there were 1 190, and in 2013, there were 1 745. I recognise that not all those cases will go on to be considered under this act, let alone under this provision. But I draw the minister's attention to the fact that things can go badly wrong in this confluence of circumstances whereby we have a person with a serious mental illness and some form of activity that, if not criminal, at least is attracting the attention of the police.

Hon HELEN MORTON: I think I heard the member say earlier that her concern is that at least somebody should monitor what is going on. Again, we have made the point that it is unlikely—in fact, not even feasible—that the Chief Mental Health Advocate would be there at the time. Whatever concern the member may have, it is not going to be monitored by the Chief Mental Health Advocate at the time it is occurring, because the likelihood of that person being there is almost nil. The person's family and other members call the police on many of those occasions to assist their family member, and themselves, in what is a really difficult situation. When we talk about the number of interventions, or incidents, or whatever it is that the member referred to, that includes the transfer of the person. At this stage, the police are the only authorised transport service in this state. This bill will permit transport by other authorised persons. If there is a concern or a complaint about the way a person is handled while in police custody in some form or another, that complaint is made to the

Corruption and Crime Commission or some other complaints office. It is not an issue for the mental health advocate to follow through on.

Hon SALLY TALBOT: I just point out to the minister that this clause is specifically about apprehension by police officers. I understand what the minister is saying about transport. But what we are dealing with here is apprehension by police officers. It is just silly to suggest that there is anything in Hon Stephen Dawson's amendment that provides that the mental health advocate will be physically present. That is not what the amendment intends or even implies.

Hon Helen Morton: Or something that is even possible.

Hon SALLY TALBOT: It is about oversight, monitoring and supervision. It is about some kind of ongoing involvement or awareness of these incidents by senior, powerful figures who are involved in the implementation of the act. I therefore think that the amendment is very well placed.

Let us go into this a little further. I would like the minister's advice on the sort of training that police who are apprehending a person have. We should remember that clause 156(1) states —

> … if the officer reasonably suspects that the person —
>
> (a) has a mental illness; and
>
> (b) because of the mental illness, needs to be apprehended …

Can the minister tell us what guarantees are in place that police officers will have the capacity to make this judgement and that this judgement will be based on some degree of specialist training or other forms of education or experience?

Hon HELEN MORTON: The honourable member was on the same committee as I when the Commissioner of Police was talking to us about the training program that graduates in mental health services undertake, so I know that she is aware of that. That training program is led by the Department of Health and by mental health emergency response line staff. I cannot tell the member right now whether that program goes for five days or 10 days, how many hours it involves or what topics are covered, but I know that we were both reasonably satisfied at the time we participated on that committee that the training was quite substantive in that it enabled police officers to undertake —

Hon Sally Talbot: That was stop and search.

Hon HELEN MORTON: That was. It was around the implications of dealing with people with a mental illness —

Hon Sally Talbot: Sorry, minister; I do not think that you can say —

The DEPUTY CHAIR (Hon Simon O'Brien): Order! Let us have one at a time. The minister is on her feet, so let her speak.

Hon HELEN MORTON: I am just referring to the discussion that took place a short while ago. Even since then, there has been enhanced training for police officers. If the member wants the specifics, I do not have them here. I do know that each police graduate receives training and then has to have ongoing training on an annual basis. These people do not have any mechanism, skill or knowledge on how to approach somebody with a mental illness or how best to assist a person when making a transport order or being involved with the police in that way. Their approach to search-and-seizure powers is quite specific. Obviously, the police know what they are doing in that respect. Again, the education and training of police will be included in the bill's implementation process, which will again help to ensure compliance with that requirement under the bill. Should there be a major concern from either a family member or a patient, they will always have the opportunity to make a complaint to the Corruption and Crime Commission, which investigates police misconduct.

Hon STEPHEN DAWSON: Will all police officers who exercise powers under this new act be required to complete approved training in mental health assessment?

Hon HELEN MORTON: I am advised that no police officer can graduate without that training. The ongoing training that police will be involved in is a combination of both face-to-face and e-learning programs. They are also required to undertake training on police powers.

Hon STEPHEN DAWSON: I am aware that at the moment police go through mental health first aid training. I think, essentially, it is the equivalent of a St John Ambulance first aid course; I do not think it is anything to do with expertise. But I think that under the Mental Health Bill 2013, given the extra powers we are giving them, there should be specific training on this bill.

Hon Helen Morton: There is.

Hon STEPHEN DAWSON: The minister is saying there is. Can the minister advise of the conversations that have taken place between the Mental Health Commission and Western Australia Police so far in relation to the new bill, the new powers and the rollout of training that will occur as a result of the extra powers provided through this bill?

Hon HELEN MORTON: I would like to clarify that the bill does not provide police officers with extra powers; it is very clear though that it provides them with extra accountability. I want to make that clear and put that on the record. I am also advised that the education strategy has a specific area related to the education of police. The discussions around the sort of training required for police have already been looked at. I do not know the extent to which that has been corresponded or whether that discussion has involved the actual police, but it has certainly been raised by the implementation reference group around the area of education and training for police. I can only make an assumption that WA Police has been involved in that discussion and the development of the training requirements. There has certainly been nothing but support from WA Police for the changes in this bill. WA Police has been involved in other aspects of the bill, but I do not have at my fingertips the precise level of discussion and conversations that have taken place with the police on this particular matter. But I will say that the police have been involved in the open-space conversations around the implementation of the bill and the training requirements.

Hon STEPHEN DAWSON: A number of pages under part 11 of this bill reference the apprehension, search and seizure powers; it is not a little thing. It disappoints me that none of the minister's advisers here tonight can give us some assurance or tell us the conversations that have happened with police.

Hon Helen Morton: That is not true. I will get up and speak in a minute.

Hon STEPHEN DAWSON: I do not think the minister has told us, because I do not think she knows. That is the point the minister has made; she does not know what conversations have happened with police and she does not know how far advanced they are. Given the number of police in this state, I want to know what extra training they will get in relation to this bill because I think there are differences between this and the existing bill. I want some sort of comfort that the police have been trained properly in mental health assessment, to ensure that mental health patients who are apprehended, searched and seized under this bill are treated appropriately given the strong powers the police have.

Hon HELEN MORTON: I want to make it absolutely clear that I have already indicated the extent to which WA Police has been involved in discussions on training; it is not that that has not happened. Hon Stephen Dawson asked for incredibly specific information on what precisely had been discussed. Although I cannot give the member the specific details, I absolutely assure him that preliminary discussions have taken place about training needs. The police are involved in forums on education and in a monthly meeting with the Office of the Chief Psychiatrist. Discussion on precisely what additional training police officers will receive over and above what they currently receive will take place once the bill has passed and the implementation phase is undertaken.

Hon LJILJANNA RAVLICH: Can the minister advise how much training police officers currently receive and whether only those police officers who have received the training and are certified are able to apprehend a person suspected of having a mental illness, or can officers who have not had the training be required to perform that function in the absence of trained officers available to go out and do that particular task?

Hon HELEN MORTON: The member would have heard me say that police officers must undertake mental health training before they graduate, and annually after that. That training is delivered by mental health emergency response line staff, police negotiators and the Department of Health. Neither I nor the advisers can bring to mind at the moment whether that is three weeks or three days' training, because it is not sitting in front of us. However, I recall from conversations throughout the committee stage, when the Commissioner of Police was sitting in front of us, that the training will equip police officers with the knowledge and understanding to undertake the tasks around search and seizure powers for people with a mental illness. The training covered things such as different forms of mental illness, types of medication and the implications of that, the behaviour of people and how best to approach people under those circumstances. I do not know what additional information the member is looking for, but it is not available to me tonight in this place.

Hon LJILJANNA RAVLICH: I wonder whether the minister might bring that to this chamber, because clearly there should be some sort of standardised course provided to all police officers.

Hon Helen Morton: It is standardised.

Hon LJILJANNA RAVLICH: The minister is asking me to take her word for it, and I am saying it would be really helpful if she would provide a course outline of what they have to do. We also know from the work that we have done that police officers sometimes do not like going out to perform this particular duty and trained officers may not always be available to perform the task. In the event that only X number of officers are assigned

to do this work and they are all out on another call because of an emergency somewhere else, can the minister guarantee that an officer who has not had the training will not be sent to apprehend a person suspected of having a mental illness?

Hon HELEN MORTON: I reiterate that all graduates have the training.

Hon LJILJANNA RAVLICH: Is the minister giving an assurance that under no circumstances will a police officer who has not had the training be able to apprehend a person suspected of having a mental illness, because they would not be authorised by WA Police to in fact perform that function? This chamber needs to have that assurance; otherwise, this is totally unacceptable.

Hon HELEN MORTON: I will make one more attempt on this particular matter. I can only reiterate that part of a police officer's training is to undertake the required training on mental health. I am being asked to give a 100 per cent guarantee that someone has not slipped up somehow or other within the police training program and missed that section of the training. I do not know the circumstances under which that might happen, and I do not understand the circumstances that might lead to the terrible coincidence that the person did not do the training because they were sick or not available, yet the police did not require them to undertake that training. That level of detail is not available to me.

Hon Sally Talbot: So, support the amendment.

Hon HELEN MORTON: No. It was not about supporting the amendment; it was about me giving a 100 per cent guarantee that not one police officer has missed out on the section of their training program on mental health that they need to undergo. All I can give the member is the guarantee that there is training on mental health for police officers.

Hon LJILJANNA RAVLICH: The minister may not be able to give the guarantee tonight, but she might be able to seek advice from the Commissioner of Police that would enable her to give the assurance to this chamber tomorrow. It is not good enough for her to say that she does not know, and it is not really acceptable that she will not seek that assurance because she does not know.

The DEPUTY CHAIR (Hon Simon O'Brien): Please, member, I must take us back to clause 156 and the proposed amendment. None of that is about training for police officers or the minister taking responsibility for verifying training or anything of the sort. Although it is reasonable to ask the questions that have been asked in exploring a clause, it must not become the focus of the debate, and certainly not repeatedly so. I ask members to look at what this clause is about so that we can stay relevant.

Hon LJILJANNA RAVLICH: It is relevant from the point of view that Hon Stephen Dawson has moved an amendment in relation to the Chief Mental Health Advocate. Clearly, if the minister cannot provide us with the assurances, there will be an increased level of requirement for a mental health advocate to provide oversight in this area. I do not think that what I have asked is unreasonable, and I think the minister should be able to provide the information I have sought.

Amendment put and negatived.

Clause put and passed.

Clauses 157 to 161 put and passed.

Clause 162: Search of person while detained or admitted —

Hon STEPHEN DAWSON: I move —

> Page 121, after line 19 — To insert —
>
> (3) A police officer or authorised person who searches a person under subsection (2)(a), or seizes any article under subsection (2)(b), must, as soon as practicable after such search or seizure, notify the Chief Mental Health Advocate of such action.

Again, this is another amendment from the opposition that seeks to notify the Chief Mental Health Advocate of actions taking place under the bill. Again, I dare say, the minister will get up and say that she does not support it. However, it is important to delve into clause 162, which I will read to the house —

> **162. Search of person while detained or admitted**
>
> (1) This section applies —
>
> (a) to any of these people —
>
> (i) a patient who is admitted by a mental health service;
>
> (ii) a person who is detained under this Act at a mental health service or other place to enable an examination to be conducted by a psychiatrist;

(iii) any other person who presents at a mental health service for treatment;

(b) at these times —

(i) when the patient or other person is being admitted by, or is being received into, the mental health service or other place;

(ii) at any time while the patient or other person is being provided with treatment or care at the mental health service or other place.

(2) A police officer or authorised person who reasonably suspects that there is on or with the patient or other person any article 13 listed in section 164(2) may —

(a) search, in accordance with sections 163 and 172, the person and any article found on or with the patient or other person; and

(b) seize, in accordance with sections 164 and 172, any article listed in section 164(2) that is found on or with the patient or other person.

It seems to me that the powers that we are giving the police in this bill are a lot stronger than the powers they have in general. The powers that the police have in dealing with mental health patients under this bill are a lot stronger than the powers police have when they are not dealing with mental health patients. Can the minister confirm that and tell us the differences?

Hon HELEN MORTON: The police can search people under the current act.

Hon STEPHEN DAWSON: That is another very satisfying answer! I am aware that the police can search people under existing acts. I am asking whether powers under this clause are stronger than the powers police have when dealing with people who have not got a mental illness.

Hon Helen Morton: I had no idea that is what you were asking.

Hon STEPHEN DAWSON: That is what I am asking.

Hon HELEN MORTON: I draw the member's attention to clause 164, which states —

(2) Any of these articles may be seized —

(a) an intoxicant;

For obvious reasons. I am just looking to the member to see whether he needs further explanation about why that is a relevant item to be seized.

Hon Stephen Dawson: No.

Hon HELEN MORTON: Clause 164(2) continues —

(b) an article, including a drug that is prescribed for the person, that may pose a serious risk to the health or safety of the person or another person;

Again, I believe it is not necessary to go any further about why that could be a dangerous situation for a person in a mental health institution.

The third paragraph reads —

(c) an article that the person conducting the search believes is likely to materially assist in determining any question in relation to the person that is likely to arise for determination under this Act.

This is included in the legislation for the person's safety; I am sure that the honourable member understands and agrees with that. It is for the protection of the patient. We are sometimes criticised because patients have not been properly searched when they enter a facility, especially if they enter involuntarily, and they then use articles that have been left on them to damage themselves or others or even to hang themselves. This is about putting in place the necessary search-and-seize powers to ensure the safety of the patient. The amendment is to notify the Chief Mental Health Advocate about each person who is searched. It is not clear what the member believes the advocacy service would do upon being notified that a person has been searched. Sending an advocate to a facility each and every time a person is searched for dangerous items would be an inefficient use of the advocate's services. If the patient is an involuntary patient, there is a requirement for that information to be recorded; a record of the patient's search is made and a copy placed in the medical records, so the Chief Mental Health Advocate will have access to that information. Alternatively, if the reports are not acted upon, they will have again created extra administrative work for both clinical staff and the advocacy service for no evident purpose. The concerns regarding the exercise of search-and-seize powers may be brought to the attention of a mental health advocate or a complaints body, and these processes do not rely upon an automatic reporting requirement.

The DEPUTY CHAIR (Hon Simon O'Brien): Hon Stephen Dawson, there is already an anticipation now that we are entertaining the amendment that stands in your name. Would you like to formally move that amendment?

Hon STEPHEN DAWSON: I am getting towards that, Mr Deputy Chair. If you would like me to move it at this moment, I am very happy to.

The DEPUTY CHAIR: Perhaps in the course of your current remarks you would like to do that before you sit down.

Hon STEPHEN DAWSON: Certainly; I take your guidance, Mr Deputy Chair, on that point. I move —

> Page 121, after line 19 — To insert —
>
> (3) A police officer or authorised person who searches a person under subsection (2)(a), or seizes any article under subsection (2)(b), must, as soon as practicable after such search or seizure, notify the Chief Mental Health Advocate of such action.

We are calling for the Chief Mental Health Advocate to be notified as soon as is practicable when a search takes place or, indeed, when any article has been seized. I may be wrong, but it is my understanding that when somebody has allegedly committed a crime, he or she has certain protections under the criminal justice system, but I am not quite sure whether someone with a mental illness has the same protections.

Hon Helen Morton: Could you be more specific about what protections you're referring to?

Hon STEPHEN DAWSON: I am not sure whether the same provisions apply. If someone commits a crime there is the Criminal Code and they are dealt with by a court or whatever, but if someone who is mentally ill is detained, do they have the same protections? For example, in the case of seizure of items, if any of these articles have been seized, what will happen next? If the police seize an intoxicant, a drug or as per clause 164(2)(c) —

> an article that the person conducting the search believes is likely to materially assist in determining any question in relation to the person that is likely to arise for determination under this Act.

That is probably the wrong point to make. What will happen if a patient in detention is found to have a drug? What action will the police take? Will they take action under the Criminal Code against the person who is detained or will something else happen?

Hon HELEN MORTON: It is a bit difficult to know precisely what the member is looking for but I will try to answer his question. If a person is in possession of stolen goods or illicit drugs, nothing will stop the police from taking action. If the member is asking what will happen to the items or what will be the process for keeping a record, as I have indicated, a record of the search will be made and a copy will be placed on the medical record. If the member is asking what will happen to the articles that have been seized when a person is apprehended, that is covered in very great detail in clause 166. If he is asking whether those articles will be returned, that is covered in clause 167. It is very difficult for me to know precisely what the member is asking, so, using those examples, I am trying to give him a broad understanding of what is available to people. He asked whether a patient's rights would be equivalent to those of a person in the criminal justice system. This entire bill is about the patient's rights; they are provided for throughout this bill. Unless the member can be more specific, it is very difficult for me to know precisely where to land my answer to his question.

Hon STEPHEN DAWSON: Thank you, minister, I appreciate your teasing that out for me. Perhaps it is late in the day. My original question was: do the police have stronger powers under this bill when they are dealing with mentally ill patients than they have when they are dealing with ordinary criminals?

Hon HELEN MORTON: I would like to call on the Attorney General—if only I could. I do not have the necessary understanding of criminal law concerning what would occur to someone if they were being searched under seizure powers around criminal law. The work undertaken for this legislation is to help save a person's life and to ensure they do not damage themselves or another person when they are in a mental health facility. There is no requirement, for example, for anyone to be suspicious that they will have something on them. Although that is obviously an option for people to be suspicious about, this is about ensuring that a person is not carrying any of these items and that the person will be safe and not harm themselves inside a mental health facility to which they are admitted. Under clause 162 there must be reasonable suspicion that a person has those items on them. That again sounds to me as though it is reasonably consistent with what occurs under the police powers in a non–mental health situation as well, except I want to reiterate that this is for a totally different purpose. This is for the purpose of keeping a person safe and from harming themselves or other people.

Hon STEPHEN DAWSON: I thank the minister for her contribution. I am not quite sure I got what I wanted out of it, but I also understand I have not quite asked the question that I wanted to. I will leave that alone for the moment. I will go back to the amendment that calls for the Chief Mental Health Advocate to be notified if any of these things take place. If a mentally ill patient gets in trouble in the system, I believe that there should be somebody informed who is on their side so they can assist them and give them advice, and also so they can be

aware of it and monitor it. If ever there is a reason to go back to look at the files or whatever, the Chief Mental Health Advocate will have been notified in the past. I guess it gets down to the fact that we see the Chief Mental Health Advocate having a stronger role under this bill; being involved or being told of more events following on from the bill. The minister obviously has a different view. I think that is probably where we will leave it.

Amendment put and negatived.

Hon ADELE FARINA: I was going to ask this question earlier but the Deputy Chair asked Hon Stephen Dawson to move his amendment, so I thought I should let him conclude the amendment. My line of inquiry is a bit different from that of Hon Stephen Dawson. I note that clause 162(1)(a) applies to any of these people —

(i) a patient who is admitted by a mental health service;

(ii) a person who is detained under this Act at a mental health service or other place to enable an examination to be conducted by a psychiatrist;

They are the key parameters in which this clause comes into operation. My concern relates to situations involving patients being transported by ambulance or some other mode of transport to these mental health service facilities or to another place to be assessed by the psychiatrist. A search is not being conducted until the patient gets to that location, which raises in my mind a question: if they have something on them that could be of danger to that person or to another person in that person's company, a search would need to be undertaken a little earlier so that paramedics and whoever else is in the ambulance are protected while the person is being transported. Why leave it until this point to conduct the search?

Hon HELEN MORTON: I am looking for the appropriate clause to demonstrate it. A search can take place at an earlier stage—at the time the transport order has been made. I will direct the member to the appropriate clause. I am advised that it is clause 149(1)(a).

Hon ADELE FARINA: Did the minister just refer to clause 149(1)(a)? It reads —

… a police officer to do these things —

(a) apprehend the person and, for that purpose, exercise the powers under sections 159(2) and 172;

However, the powers for actually searching are detailed in clause 162.

The DEPUTY CHAIR (Hon Simon O'Brien): Did Hon Adele Farina wish to resume her seat so that the minister can receive the call?

Hon ADELE FARINA: No, I was just reading those clauses before I sat down so that I could make sure that I am actually right. In fact, clause 159 appears to be broader than clause 162. It says that the police officer can search the person for any article. It seems to go much further than the proposal in clause 162. If that is the case, I would like some explanation for why the search pursuant to clause 159 is much wider than the search proposed at clause 162.

Hon HELEN MORTON: It is not. Clause 159(2) makes it clear that the police officer may —

(b) search, in accordance with sections 163 and 172, …

(c) seize, in accordance with sections 164 and 172, any article listed in section 164(2) that is found on or with the person.

Hon ADELE FARINA: Clause 163 refers to how the search is to be conducted, not what can be seized, and clause 172 deals with reasonable assistance and force that can be used while conducting the search. Neither of those provisions deals with what can be seized. Clause 162 deals with what can be seized, and I think clause 159 is broader than what is provided for in clause 162.

Hon Helen Morton: No, it's not.

Hon ADELE FARINA: It may not be intended to be.

Hon Helen Morton: No. Have a look at clause 159(2)(c); it categorically states "any article listed in section 164(2)".

Clause put and passed.

Clauses 163 to 178 put and passed.

Clause 179: Patient's psychiatrist must ensure regard had to patient's wishes —

Hon SALLY TALBOT: I wonder whether I could ask the minister for her consideration on whether clause 179 goes far enough in specifying information that the patient must be provided with. This clause is called "Patient's

psychiatrist must ensure regard had to patient's wishes". I am not sure about the grammar of that heading but we will go with it anyway. A number of things are outlined in this clause having regard to the patient's wishes but there is no specific reference to what the patient has to be told. I am wondering, for example, about alternative treatments.

Hon HELEN MORTON: Clause 180(2) states —

> For the purpose of subsection (1), sections 19 and 20 apply (with the necessary changes) in relation to ascertaining the patient's wishes in relation to the provision of the treatment.

The member needs to look at clauses 19 and 20, which outline the requirements in that respect.

Hon SALLY TALBOT: The minister can save me a bit of time, given she referred to clause 180, and I am perhaps in need of a slight indulgence from the Deputy Chair here. What are those changes? I am raising this here, Mr Deputy Chair, only because the minister specifically referred to clause 180(2). What is the reference to the necessary changes?

Hon HELEN MORTON: We are taking a bit of time to get the corresponding reference in the bill to the words in brackets.

Hon SALLY TALBOT: May I make a suggestion, Mr Deputy Chair? I wonder whether, given the time—this is a pretty important point—the minister would like to provide this information to the opposition in the morning?

Hon HELEN MORTON: No, I have the information right now. The reference around the requirements for ascertaining a patient's wishes at clause 180(2) is that for the purposes of subclause (1), clauses 19 and 20 apply with the necessary changes when ascertaining the patient's wishes for the provision of treatment. Clause 19 makes it clear that before a person is asked to make a decision about the provision of treatment to a patient, that person must be provided with a clearer explanation of the treatment. The words "before a patient is asked to make a treatment decision" in clause 19 are not necessarily relevant to involuntary patients. The changes refer to the fact that an involuntary patient is not required to make a decision about the provision of treatment. Clause 19(1) states —

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

Similarly, clause 20 states that a person cannot be asked to make a treatment decision about the provision of treatment to a patient unless the person is given that level of information. The relevant changes are that an involuntary patient does not need to be asked to make a treatment decision and that does not need to be done under clause 20 either.

The necessary change might be before the patient is asked to express their wishes, for example.

Hon SALLY TALBOT: Has the minister not just said that clauses 19 and 20 do not apply to involuntary patients?

Hon Helen Morton: Just the first part of it, because at clauses 19 and 20 we are talking about all patients, whether they are involuntary or voluntary. So, the necessary change in this clause is that an involuntary patient does not need to be asked to make a decision—only to express their wishes.

Hon SALLY TALBOT: I am mystified. Does the minister really think that is as clear as it possibly can be? Subclause (2) uses the words —

> … (With the necessary changes) …

With the greatest respect to the minister—who is the person in the whole world who is supposed to get her head around this legislation, more than anybody else—it took the minister a while to sort that out —

Hon Helen Morton: Not really.

Hon SALLY TALBOT: That is not acceptable, minister. The minister knows that is not acceptable. She is the minister.

Hon Helen Morton: I meant it did not take me a long time—it was two seconds.

Hon SALLY TALBOT: I thought the minister meant she was not the person with her head around the legislation.

Hon Helen Morton: No. I am saying it did not take me a long time—it was two seconds.

Progress reported and leave granted to sit again, on motion by Hon Helen Morton (Minister for Mental Health).